DETAILED IMPLEMENTATION PLAN (DIP)

Providing Child Survival Services to Rural and Peri-Urban Populations in Bolivia
Cooperative Agreement No. HFP-A-00-02-00035-00
Project Start Date: October 1, 2002
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Providing Child Survival Services to Rural and Peri-Urban Populations in Bolivia
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Interventions:
25% Nutrition (including breastfeeding promotion)
25% Maternal and Newborn Care
20% Control of Diarrheal Disease
20% Pneumonia Case Management
10% Immunizations

Beneficiary Populations: 37,100 children under five years of age and women of reproductive age (8,381 are children under five years of age, and 16,581 are women of reproductive age)

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LIST OF ACRONYMS

CAI	Information Analysis Committee
CARE	Cooperative for Assistance and Relief Everywhere, Inc.
CB-IMCI	Community Based Integrated Management of Childhood Illness
CBC	Communication for Behavior Change
CBIO	Census-Based Impact Orientation
CHW	Community Health Worker
CS	Child Survival
CSRA	El Consejo de Salud Rural Andino
CSTS	The Child Survival Technical Support Project
DIP	Detailed Implementation Plan
DILOS	Local Health Board
DDPC	Desarrollo Democratico Participacion Ciudadana
EPI	Expanded Program for Immunizations
HV	Health Volunteer
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
KPC	Knowledge, Practices and Coverage
MCH	Municipal Health Council
MOH	Ministry of Health
NGO	Non-governmental Organization
QAP	Quality Assurance Project
ORS	Oral Rehydration Salts
PAHO	Pan American Health Organization
PROPAN	Process for the Promotion of Child Feeding
SNIS	National Health Information and Statistics System
TARI	Talleres Abiertos sobre Reciprocidad e Cross-culturalidad
TIPS	Trials of Improved Practices
TT	Tetanus Toxoid
USAID	U.S. Agency for International Development
WHO	World Health Organization

SECTION A: EXECUTIVE SUMMARY

This document is a detailed implementation plan (DIP) for Curamericas' new entry Child Survival Project (2002-2007), *Providing Child Survival Services to Rural and Peri-Urban Populations in Bolivia.* Project activities began on October 1, 2002 and will continue through September 30, 2007. The project's goal is to reduce child and maternal deaths and morbidity by improving maternal, neonatal, and infant health care services in the proposed project areas. Its program strategies and interventions depend on the active participation of local stakeholders, and incorporate suggestions made by USAID proposal reviewers as well recommendations from Curamericas previous child survival final evaluation (see Annex B for specific responses to DCHA/PCV Child Survival Application Debriefing Summary Sheet and Final Evaluation Recommendations).

The target areas for the project will be peri-urban sites, in the municipality of Montero (Obispo Santistevan Province, Santa Cruz department) and El Alto's District Eight (Murillo Province, La Paz department), which includes the neighborhood of Senkata (see Annex A for project site maps). Currently, Montero's three active health centers, Villa Cochabamba, Cruz Roja and Clem serve 4,044 households in adjacent communities and each offers a variety of health services that include basic maternal and child health, laboratory facilities and a pharmacy. The El Alto health center recently opened and will be offering similar maternal, child and dental services. It also has a maternal center, in-patient accommodations, and delivery facilities.

The primary causes of death and morbidity among preschool children include pneumonia, diarrhea, malnutrition, asphyxia, and sepsis. Pre-eclampsia, hemorrhage, and infections are primary causes of death among women of reproductive age. Bolivia is second only to Haiti in the Western Hemisphere in terms of mortality of children under five years of age. The national under-five mortality rate for Bolivia is 80 per 1,000 live births and the infant mortality rate is 67 per 1,000 live births[1]. The national maternal mortality rate is 390 per 100,000 live births[1]. These rates vary widely within Bolivia depending on geography, income, education, and urban/rural location. The proposed service areas are very marginalized, and we expect mortality rates to be well above the national average for these areas.

Over 37,100 women, infant and children will be reached by the child survival interventions in the proposed service areas where there are 77 urban and peri-urban neighborhoods. The table below describes the target group population for both project sites at the beginning of the project.

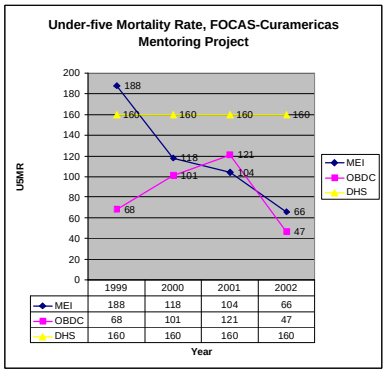
Program Site Population by Target Groups (2002)

Target Group	Montero	El Alto (District #8)	Total
Infants 0 – 11 months	619	890	1,509
Children 12 – 23 months	723	926	1,649
Children 24 – 59 months	2,244	2,979	5,223
Women of Reproductive age (15-49 years)	6,989	9,592	16,581
Total Direct Beneficiaries	10,575	14,387	24,962
Other Indirect Beneficiaries	16,261	21,187	37,448
Total Population	26,836	35,574	62,410

Source: *National Institute of Statistics* 2002 for El Alto, Actual Census Data from Villa Chochabamba and Cruz Roja in 2001, and Actual Census Data from Clem in 2002, Montero.

[1] National Health Information and Statistics System, La Paz, Bolivia.

The project goal will be achieved through a focus on several key objectives. These include strengthening the capacity of community health workers (CHWs) and health volunteers (HVs) through training, and increasing access to child survival (CS) services through home visit and clinical consultations; increasing demand for health prevention and treatment services through health education, the Integrated Management of Childhood Illnesses (IMCI) approach, and community maternal and neonatal health care strategies; and, increasing the capacity of project personnel, municipal governments and the MOH to successfully plan, budget, implement and evaluate sustainable community child survival services. These objectives will be achieved by offering five key child survival interventions (with the corresponding estimated level of program effort): nutrition and micronutrients – 25%; maternal and newborn care – 25%; control of diarrheal disease – 20%; pneumonia case management – 20%; and immunization – 10%.



These interventions will be implemented through a series of innovative activities designed to further strengthen program impact. First, we will implement the census-based, impact-oriented (CBIO) methodology of primary health care within the communities that will be served. The under-five mortality rate decreased by almost 75% in our service areas in Bolivia during the previous eight years (see graph, right), due in part to our CBIO methodology.[2] The CBIO methodology ensures that all beneficiaries are contacted on a routine basis. Community health volunteers conduct prevention education sessions and gather health data and information about births, deaths and migration. This process ensures that health care is available to even the remote homes and information is available to prevent and treat the most common causes of sickness and death.

The second project strategy is to implement IMCI and community-based IMCI (CB-IMCI) within the program areas. CB-IMCI complements the CBIO methodology and will strengthen the capacities of communities to recognize, treat and prevent common childhood illnesses including malnutrition, pneumonia, and diarrhea. The IMCI strategy will be bolstered with the introduction of an intercultural program that improves attitudes, practices and relationships of health personnel, traditional healers and local authorities.

The project will improve neonatal and maternal health outcomes by strengthening CHWs, HVs, communities, and mothers to prepare and plan for pregnancies. Strategies include increasing access to maternal health and safe delivery services, improving community identification of obstetric emergencies, increasing the maternal and neonatal health skills of CHWs and HVs, and providing postnatal and newborn care in the household and in the clinic. Finally, the project will also utilize communication for behavior change, quality assurance approaches and supervision as additional strategies to improve practices and health outcomes.

Curamericas will work with the local Bolivian NGO, Consejo de Salud Rural Andino (CSRA). Curamericas and CSRA have been partners in the successful implementation of three previous CS grants in Bolivia. CSRA originally was the local arm of Andean Rural Health Care (now known as Curamericas), supervised directly by the US headquarters office in North Carolina. In 1995, CSRA was incorporated legally in Bolivia with its own Board of Directors and nonprofit

[2] Shanklin, D. Dramatic Reductions of Childhood Mortality in Three Bolivian Child Survival Projects. PVO High Impact Symposium, Washington, DC, June 21-23, 1998.

statutes. Although both organizations remain close, the organizations are legally separate and CSRA is accountable directly to its Board of Directors. CSRA has a central office in La Paz, the Bolivian legislative capital.

Curamericas and CSRA have implemented PHC activities since 1983 and currently are working in three municipalities in Bolivia. In the project sites (El Alto and Montero), CSRA personnel include the project site directors (all physicians), nurses, auxiliary nurses and administrative and financial support staff. Curamericas and CSRA work with the local municipalities and MOH health districts to co-administer the local primary health care system whose staff includes physicians, nurses, CHWs and HVs.

The proposal calls for USAID to provide $1,300,000 for project implementation, and Curamericas and its partners will match this amount with at least another $1,300,000. The cost per beneficiary outlined in the table below was calculated based upon annual growth rates (11% District Eight of El Alto and 4% in Montero) and included new births (20% annual increase).

Cost per Beneficiary

	Year 1	Year 2	Year 3	Year 4	Year 5
TARGET POPULATION					
Pre-school children	8,381	9,055	9,792	10,600	11,487
Women of reproductive age	16,581	17,913	19,372	20,972	22,725
Subtotal	24,962	26,968	29,164	31,572	34,212
New Births	1,676	1,811	1,958	2,120	2,297
TOTAL	26,638	28,779	31,122	33,692	36,509
USAID Financing	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000
Cost per Beneficiary, USAID Funds	**$9.76**	**$9.03**	**$8.35**	**$7.72**	**$7.12**
Total Financing	2,600,000	2,600,000	2,600,000	2,600,000	2,600,000
Cost per Beneficiary, all funds	**$19.52**	**$18.07**	**$16.71**	**$15.43**	**$14.24**

Sujata Ram, an independent public health consultant, is the author of this DIP. Stanley Blanco, USAID/Bolivia Technical Manager, is the USAID contact for this project. The HQ CS backstop and contact person for this project is Craig Boynton, Curamericas' Country Program Coordinator. He may be contacted at: 224 East Martin Street, Raleigh, NC 27601; telephone 919-821-8000; or, by e-mail at craig@curamericas.org.

SECTION B: CSHGP DATA FORM

Child Survival Grants Program Project Summary

DIP Submission: Apr-28-2003
Curamericas Bolivia

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Project Information:

Project Description:	The project will focus on improving maternal, neonatal, and infant health care services in the proposed project areas. CS-18 will strengthen community support through the training of CHWs and health volunteers (HVs), and increase access to CS services through home visit and clinical consultations; increase demand for health prevention and treatment services through health education, the Integrated Management of Childhood Illnesses approach, and community maternal and neonatal health care strategies; and, increase the capacity of CSRA, municipal governments and the MOH to successfully plan, budget, implement and evaluate sustainable community child survival services. This will be achieved by offering four key child survival interventions: nutrition and micronutrients; maternal and newborn care; control of diarrheal disease; pneumonia case management; and immunization
Partners:	Curamericas will work with the local Bolivian NGO, Consejo de Salud Rural Andino (CSRA).

Project Location:	The target area for the project will be peri-urban sites, in the municipality of Montero (Obispo Santistevan Province) located in the department of Santa Cruz and the municipality of El Alto's District Eight (Murillo Province), which includes the neighborhood of Senkata.

Grant Funding Information:

USAID Funding:(US $)	$1,300,000	**PVO match:(US $)**	$1,300,000

Target Beneficiaries:

Type	Number
infants (0-11 months):	1,509
12-23 month old children:	1,649
24-59 month old children:	3,158
0-59 month old children:	8,381
Women 15-49:	16,581
Estimated Number of Births:	2,491

Beneficiary Residence:

Urban/Peri-Urban %	Rural %
100%	0%

General Strategies Planned:
Strengthen Decentralized Health System

M&E Assessment Strategies:
KPC Survey
Health Facility Assessment
Organizational Capacity Assessment with Local Partners
Organizational Capacity Assessment for your own PVO
Lot Quality Assurance Sampling
Community-based Monitoring Techniques
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:
Mass Media
Interpersonal Communication
Peer Communication
Support Groups

Capacity Building Targets Planned:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HQ (General)	Local NGO	Traditional Healers	Dist. Health System	Health CBOs

Field Office HQ CS Project Team			Health Facility Staff	Other CBOs CHWs

Interventions:

Immunizations 10 **%**
** IMCI Integration
** CHW Training
** HF Training
*** Polio
*** Classic 6 Vaccines
*** Vitamin A
*** Surveillance
*** Injection Safety
Nutrition 25 **%**
** IMCI Integration
** CHW Training
** HF Training
*** Comp. Feed. from 6 mos.
*** Growth Monitoring
** CHW Training
** HF Training
Acute Respiratory Infection 20 **%**
** IMCI Integration
** CHW Training
** HF Training
*** Pneum. Case Mngmnt.
*** Case Mngmnt. Counseling
*** Recognition of ARI Danger Signs
Control of Diarrheal Diseases 20 **%**
** IMCI Integration
** CHW Training
** HF Training
*** Hand Washing
*** ORS/Home Fluids
*** Feeding/Breastfeeding

*** Care Seeking
*** Case Mngmnt./Counseling
Maternal & Newborn Care 25 **%**
** IMCI Integration
** CHW Training
** HF Training
*** Recog. of Danger signs
*** Newborn Care
*** Post partum Care
*** Normal Delivery Care
*** Birth Plans
** IMCI Integration
** CHW Training
** HF Training

Indicator	Numerator	Denominator	Estimated Percentage	Confidence line
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	50	571	8.8	2.4
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	105	319	32.9	5.1
Percentage of children age 0-23 months whose births were attended by skilled health personnel	461	683	67.5	3.5
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	474	683	69.4	3.5
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	119	167	71.3	6.9
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	57	121	47.1	8.9
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	76	228	33.3	6.1

Percentage of children age 12-23 months who received a measles vaccine	134	228	58.8	6.4
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	0	0	0.0	0.0
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	199	683	29.1	3.4
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	29	61	47.5	12.5
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	164	569	28.8	3.7
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	30	683	4.4	1.5

Rapid CATCH Indicators

Indicators	Project Average %	Nominator	Denominator	Confidence Intervals*	
				LCL	UCL
% of children age 0–23 months who are underweight (-2 SD from the median weight-for-age)	8.8%	50	571	6.4%	11.1%
% of children age 0–23 months who were born at least 24 months after the previous surviving child	32.9%	105	319	27.8%	38.1%
% of children age 0–23 months whose births were attended by skilled health personnel	67.5%	461	683	64.0%	71.0%
% of mothers who received 1 dose of TT in their last pregnancy (modified RapidCATCH indicator)	69.4%**	474	683	65.9%	72.9%
% of children age 0–5 months who were exclusively breastfed during the last 24 hours	71.3%	119	167	64.4%	78.1%
% children age 6–9 months who received breast milk and complementary foods during the last 24 hours	47.1%	57	121	38.2%	56.0%
% of children 12 to 23 months fully vaccinated before the age of 13 months (modified RapidCATCH indicator)	33.3%	76	228	27.2%	39.5%
% of children 12 to 23 months with measles vaccination	58.8%	134	228	52.4%	65.2%
% of mothers with children age 0–23 months who cite at least two known ways of reducing the risk of HIV infection	28.8%	164	569	25.1%	32.5%
% of mothers with children age 0–23 months who report that they wash their hands with soap before food preparation, before feeding children, after defection, and after attending to a child who has defecated	4.4%	30	683	2.9%	5.9%
% of mothers with children 12 to 23 months who recognize at least 2 dangers signs that indicate the child needs treatment (modified RapidCATCH indicator)	29.1%	199	683	25.7%	32.5%
% children age 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks	47.5%	29	61	35.0%	60.1%

SECTION C: DESCRIPTION OF DIP PREPARATION PROCESS

The DIP preparation process follows the guidelines set forth in USAID/GH/HIDN's revised Child Survival Grants Program Guide for Detailed Implementation Plans and conducted the following key activities[3]:

- Collected baseline quantitative and qualitative data that informed program strategies;
- Created a shared vision among partners and strengthened relationships;
- Revised and refined program objectives, indicators and targets;
- Refined program strategies on key project interventions;
- Planned principal project tasks and activities and develop a work plan for the project's first two years; and,
- Prioritized, planned activities and revised the project budget.

CSRA and Curamericas employed an external consultant to guide the field and HQ project staff in the preparation of the DIP, which serves as the detailed guide for the project (a scope of work can be found in Annex C). The consultant visited Montero during the period of March 6 to 11, 2003 and La Paz and El Alto from March 11 to 21, 2003 to begin the planning and organization of the DIP with the CSRA Child Survival Team (specific schedules and work plan during this period can be found in Annex C). In Montero and La Paz, the consultant conducted in-depth interviews with the project's field and headquarter personnel. Specifically, the consultant met with field coordinators, technical mangers, and managers of the information system and CBIO approach, finance director, and CSRA national director.

Participatory workshops were held in Montero and El Alto with field level personnel to review baseline results, revise program objectives and indicators and develop a detailed work plan for the first two years of the project implementation as well as a plan for the life of the project. Montero also held a collaborative workshop with local municipal and district health authorities, health volunteers (HVs) and health personnel. The primary purpose of this workshop was to obtain input and commitments from local health officials. During this meeting, participants discussed institutional coordination, the use of communication for behavior change and IMCI strategies, and community surveillance activities. Participants were asked to develop an action plan and identify principal activities, methods and strategies to conduct these activities, and a proposed timeline for implementation.

At the conclusion of the consultant's visit to La Paz, an all day meeting was convened with CSRA senior managers in order to present results of the workshops, revised program strategies and budget and discussed outstanding issues and next steps (agendas and lists of participants of all meetings and workshops will be found in Annex C).

A Curamericas representative along with the project director will participate in the technical workshop (or mini-university) in Washington D. C. as part of the DIP review process. Results of the workshop will be shared with field personnel and CSRA managers.

[3] USAID/GH/HIDN. September 2002. "Child Survival Grants Program Guide for Detailed Implementations Plans." Washington, DC.

SECTION D: REVISIONS FROM ORIGINAL PROPOSAL

Several budget revisions were necessary to reflect changes in the number and location of project sites, additional program strategies and personnel and other items that were in the project proposal but were not incorporated in the original budget. No additions or deletions of child survival interventions have taken place.

Change in Project Sites

The project originally proposed to implement child survival activities in five geographical areas in the departments of La Paz and Santa Cruz: Ambana, Puerto Acosta, Alto Beni, El Alto in La Paz and Montero in Santa Cruz. Due to several political and social changes in several of these areas, however, the project has decided to only implement activities in El Alto and Montero. (More information is provided below on the reasons for this change.) The expected number of target beneficiaries will remain as stated in the proposal (see Table below).

Targeted Beneficiaries

Population	El Alto	Montero	Total
YEAR 1			
Targeted Beneficiaries	15,970	10,998	26,968
Expected Population	39,487	27,909	67,396
YEAR 2			
Targeted Beneficiaries	17,726	11,438	29,164
Expected Population	43,830	29,025	72,855
YEAR 3			
Targeted Beneficiaries	19,676	11,895	31,572
Expected Population	48,651	30,186	78,837
YEAR 4			
Targeted Beneficiaries	21,840	12,371	34,212
Expected Population	54,002	31,393	85,395
YEAR 5			
Targeted Beneficiaries	24,243	12,866	37,109
Expected Population	57,334	32,648	89,982

Source: *National Institute of Statistics* 2002

The difference between the original proposal's target beneficiaries will be compensated for primarily in El Alto, which has an annual population growth rate of 11%, considered to be one of the fastest growing regions in the country. Montero's current growth rate is 4%. Given these growth rates, by the conclusion of the project, the total target population will reach 37,100 in both areas. El Alto's municipal government has expressed a desire to work with CSRA in District Eight, a recently formed municipal district, which is classified as one of the fastest growing region in El Alto. CSRA has been working in three peri-urban areas of Villa Cochabamba, Cruz Roja and the new area (Clem) in Montero.

Historically, CSRA has provided primary healthcare services to underserved, largely indigenous populations in mostly rural areas of Bolivia. Since the mid-1990's, however, political changes in the government's structure has propelled the partnership to re-consider their strategic decision to work solely in rural areas. Bolivia's decision to decentralize their governance structure so that local municipal entities have more power and control over management and financing of their

health programs, has led CSRA/Curamericas to adapt their program strategies to strengthen the capacity of municipality and district health offices to better effectively and efficiently manage health care systems.

Between 1995, the year the Law of Popular Participation became operational, and 2001, CSRA promoted and successfully leveraged relatively high levels of municipal investment in the local health systems, including expenditures on recurring operating costs. CSRA also successfully engaged municipal authorities in the decision-making processes related to the functioning of their health systems. CSRA negotiated and maintained written agreements with successive municipal governments and the MOH. Several of CSRA's strategies were fairly high risk: consistently pressuring local governments to invest in health, when other sectors such as education and productive infrastructure are legitimate competitors; pressing officials to invest in operating costs as opposed to often over sized infrastructure plans; consistently increasing the number of staff paid by the MOH, who when changing their employer, tend to reduce their commitment to CSRA directives and work plans; openly sharing institutional financial information; and finally, the willingness to share administrative responsibilities with partner representatives from the MOH and municipal governments.

Since the submission of the original proposal, CSRA has experienced difficulties in securing the necessary commitments from municipality and MOH authorities in Ambana and Puerto Acosta. After several years that agreements were being honored, CSRA was faced with severe non-compliance issues resulting from internal problems within the municipal governments, direct interference from the local MOH representative, and lack of support from higher levels in the ministry due to the pre-electoral authority void during 2002. CSRA, faced with the prospect of continuing non-compliance decided to discontinue its activities in those two municipalities.

In Alto Beni, CSRA experienced similar political frustrations. CSRA began collaborating with municipal officials and community representatives in mid-2001 in order to plan initial start-up activities. During this process it was discovered that in one area, the municipal government was working "in exile" and employees were actually based in La Paz due to a lack of trust and support among the Vigilance Committee and community leaders. Community leaders were calling for a freeze of funding until unresolved issues were discussed. Community leaders from the other area were also threatening to freeze financing and bank accounts. Given this unstable environment, CSRA and Curamericas determined that these local municipalities were not in the position to guarantee the financial and human resources necessary to implement a child survival project.

As a result of these changes the new revised budget will transfer human resource, training, and equipment funds to El Alto and Montero in order to serve the total target population during the life of the project (see Annex D for Budget Forms 424 and 424A and Budget Narrative).

The reduction in the number of project sites will help CSRA concentrate its activities and lower the costs of project dispersion over five years. CSRA and Curamericas, however continue to face risks and challenges to implement the project in El Alto. For example, in El Alto, CSRA has a signed agreement in place with the municipality and mayor's office, which has delegated the administration of the new health center in Senkata to CSRA. The municipality has already provided $120,000 for the construction of the center. However, a commitment for the provision of matching operational funds to obtain additional personnel and equipment currently does not

exist. At present, CSRA has a good working relationship with a current council member and the mayor of El Alto who are both equally supportive of CSRA activities. The political situation, however, could become volatile as the mayor is up for re-election in two years and will probably not be re-instated. The indigenous parties are very active in the area and will be running the elections. The current climate for NGOs is also not the best. While CSRA is the only health NGO in the project areas, dozens of others exist in El Alto and they are all vying for additional resources from the municipality. As a result there is a certain weariness of NGOs among municipal officials. In addition to these social and political challenges, CSRA will no longer have matching resources from Alto Beni and the other areas, which therefore increases their dependency upon a reduced number of sites.

The situation in Montero is more stable but CSRA and Curamericas currently do not have a signed agreement with the municipality. They would, however, like to work more closely with local authorities. Given this situation, CSRA's financial situation is vulnerable. If the political situation deteriorates then resource constraints will emerge. CSRA is currently negotiating an agreement with officials to enter into the Social Child and Maternal Health Insurance or SUMI program and also to provide additional human resources.

Given these risks and challenges, CSRA has developed a contingency and emergency plan that outlines specific activities if additional modifications are required. Curamericas and its Board of Directors are currently reviewing this plan.

Additional Strategies and Personnel

The project has identified several new program approaches (since the submission of the proposal), which will better help CRSA reach project goals, objectives, and targets. For example, CSRA has expanded its Census-Based, Impact-Oriented (CBIO) methodology by developing a new model that emphasizes a greater role for the community in analyzing health data and designing and implementing activities (additional information can be found in Section E). This change is reflected in the budget with the addition of a percentage of the CBIO manager's salary.

CSRA's new strategic direction has meant an increasing emphasis on strengthening the capacities of municipal governments to better plan, manage and administer health resources. To better address this, CSRA will be employing a technical manager who has had previous experience working with USAID funded *Desarrollo Democratico Participacion Ciudadana* (DDPC) project, to manage and plan relations with municipal governments. DDPC's and other model will be adapted to local conditions, and along with accompanying materials will be used to address capacity building for municipality authorities and in particular emphasize the active involvement of local health boards. In El Alto, CSRA will be actively involved in the development of a "Health Master Plan" for District Eight. The plan will be a mapping scheme that will identify schools, parks and current and future health center sites. The plan will incorporate population growth figures to determine the necessary number of centers and hospitals for the district. The local health boards will be actively involved in this process and will benefit from CSRA led capacity building activities.

In order to better address inter-cultural aspects, CSRA is also working with TARI (*Talleres Abiertos sobre Reciprocidad e Cross-culturalidad*), a NGO with expertise in anthropology and also located in El Alto, to develop a program (see Annex E for cooperative agreement). This

new strategic program complements the IMCI strategy and will be discussed in a subsequent section. The budget revisions associated with this strategy include the addition of costs associated with educational materials and workshops and a cross-cultural consultant.

Other strategies such as quality assurance and communication for behavior change programs have also been further developed since the proposal was submitted. Changes to the budget include additional resources for educational materials, workshops and meetings. The proposal budget also did not include funding for the IMCI manager, which now has been included. Workshops for various methodologies that were originally proposed such as the Positive Deviance, Barrier Analysis and Plan for Pregnancy are now incorporated in the new budget.

Other items not included in proposal

The original budget did not include several operational and programmatic items. For example, local travel for staff between the two sites did not exist and has been added to the new budget. In addition, several administrative and management positions in the central and regional offices have also been added. For these positions, only a portion of their total time will be charged to the project. Costs for several routine monitoring events such as workshops, monthly meetings and mini-surveys have been incorporated as well (see Annex D for Budget Forms 424 and 424A and Budget Narrative).

SECTION E: DETAILED IMPLEMENTATION PLAN

Program Monitoring and Evaluation Plans

Information Systems

Two information systems, the MOH's National Health Information and Statistics System (SNIS) and CSRA's own system, are currently in place that collect and tabulate all community and health center data from project sites. A current agreement is in place with the MOH that allows CSRA to use its own forms in conjunction with SNIS reports to collect community level data. Currently, an evaluation is underway to evaluate this agreement and determine whether to continue as originally conceived or change the project's reporting documents to that of the MOH system.

All project health personnel currently use both CSRA and SNIS forms during home and health center visits. SNIS reports collect health information based upon the MOH's current norms and practices. CSRA's complementary system has been developed to collect additional information that is not included in the SNIS reports and to target various groups and services. Registers are used to collect information regarding women, children, vital events, and external consultations.

Project HVs, supervised by CHWs, maintain records of their community-based activities and home visits to capture household level information. This information includes the name of each family member, sex and ages of members, reported illnesses, prescribed treatment, whether any referral has taken place, current family planning methods, and a description of the specific counseling session. Health personnel also collect information regarding vital events including births and deaths in the household and information regarding migration, and results of verbal autopsies, which provide important information on the number and causes of deaths of children and women of reproductive age (which is reviewed on a regular basis). Additional household information such as the existence of a drinking water and sanitation system is also collected. During home and health center visits, health workers also complete child and maternal health cards to record growth monitoring, vaccination status, micronutrient supplementation, and prenatal controls. Duplicate cards and additional forms are also present in the health centers, which capture case histories of each family and the reproductive histories for of women.

At the conclusion of every month, community level data from the registers and health center forms are consolidated, and a SNIS summary form and the complementary CSRA forms are submitted to local MOH officials, other local partners (mayor's office, vigilance committee, neighborhood boards and health boards), CSRA, Curamericas and USAID. Summary data is also shared with community authorities and leaders and presented during information analysis committee (CAI) meetings. At the community level, CHWs will share data with their own respective households as part of the CBIO approach.

CSRA currently has a spreadsheet system in place in its central office that contains monthly reports and baseline data in electronic form. The project plans to implement this system in both Montero and El Alto and will begin designing a database system early in the project's implementation.

The project also plans to implement Management Sciences for Health's (MSH) Cost Revenue Analysis tool (CORE), which is a series of Excel spreadsheets used by clinical and administrative staff at the health facility level. The tool helps mid-level and senior managers of health organizations determine actual and potential costs, revenues, and surpluses or deficits at

existing or planned clinics. Spreadsheets are designed that analyze individual services and overall clinic performance using existing and projected cost, revenue, and service information. The tool calculates a number of indicators that can be used by managers to monitor costs, including level of cost recovery (by service and overall), staff utilization, and labor costs. CSRA currently has an agreement to implement CORE in the project's El Alto health center. The first year activities include adapting the software to the new changes in SUMI program and to CSRA's own needs that will incorporate all program strategies. Software training will be conducted by MSH for CSRA and will also take place during the first year of implementation. MSH is currently developing a printing system that can produce user-friendly outputs. Currently, the spreadsheets are too cumbersome and difficult to print and need to be adapted. The project is also planning on implementing the CORE tool at its Montero site in year two of implementation (See Annex E for a cooperative agreement with MSH).

Monitoring Tools

Health status and behavior data will be collected using mini-surveys using Lot Quality Assurance Sampling (LQAS), a rapid sampling method that has been used to assess child survival and maternal health interventions and provides information on each supervision area of a larger project area. LQAS results can be collected over time and incorporated into a management information system. This sampling methodology will also be used for the program's baseline and final evaluation. The short KPC questionnaire used in the mini- survey will include all of the variables needed for the proposed health and behavior indicators in the work plan. CSRA will use a modified lot quality assurance sampling approach whereby each municipality is divided into community groupings (lots). Communities within a given group will have similar characteristics. Within each lot, 19 respondents will be randomly selected and interviewed. Results from each lot are evaluated to describe indicators at the community grouping level, and then aggregated to determine point prevalences at the municipal level. The data from the mini-survey will help the program identify critical areas of intervention at the community and municipal levels.

A complete Health Facility Assessment (HFA) will be conducted during the second half of the first year essentially to evaluate the effectiveness and quality of IMCI implementation using the BASICS HFA methodology. An initial rapid assessment of essential drugs, supplies and equipment using a modified IMCI verification checklist has already taken place in the three health centers in Montero (March 2003) and additional in-depth assessments will be conducted in both sites. This preliminary study revealed that all centers have waiting areas and chairs for patients and functioning toilets and a good and reliable source of drinking water. IMCI forms and protocols are not yet available but will be supplied by the MOH. Essential drugs and supplies are well organized, current and correctly documented in an inventory register. In future sessions, the IMCI program manager and other field coordinators will routinely monitor established IMCI indicators (chosen during the HFA) in order to make improvements and strengthen weak areas of implementation. Additional assessments will collect information regarding the effectiveness of protocols, assess training needs, and evaluate the quality of services through patient satisfaction surveys[4].

CSRA's senior management will also play an important role in monitoring and planning project activities via two organizational mechanisms, the Implementation Committee and Senior

[4] http://www.foodaidmanagement.org/worddocs/moneval/toolkit/Exit_Interviews

Management Committee. The Implementation Committee, which includes the project's Field Coordinators and Technical Managers in La Paz, meet monthly to coordinate activities and every 3 months to evaluate project activities. During this time, managers present progress reports and major activities and the work plan are assessed and modified. Project activities are coordinated on a monthly basis. The Senior Management Committee generally does not meet on a regular basis but receives monthly progress reports from technical managers and field coordinators.

All personnel including representatives from the community and municipality will develop annual operative plans – which contain the project's key activities – at each project site. This plan will be evaluated by field level staff, community and municipal representatives, and CSRA´s senior personnel every three months and at the conclusion of the year.

In addition to routine monitoring activities, the project will conduct a midterm evaluation in the third year of implementation. The evaluation, led by an external consultant will assess the process of implementation of program interventions and compare the project's proposed targets to those stated in the DIP. The primary purpose of a midterm evaluation is to examine the process of implementation and determine whether project goals and objectives are being met. The principle activities include assessing progress in implementing the project's DIP, determining if interventions are sufficient to achieve outcomes, identifying barriers to achievement of objectives, and providing recommendations for program staff to modify the work plan and monitoring system.

Data Collection

A baseline Knowledge, Practices and Coverage (KPC) survey was conducted in December 2002, and January and February of 2003. It was based on the Child Survival Technical Support Project's (CSTS) recent reviews of the KPC questionnaire and process and includes the RapidCATCH indicators. Both quantitative and qualitative baseline data was collected through the KPC, focus group discussions and in-depth interviews. The survey targeted mothers with children under two years of age. In addition to women, men and local authorities were targeted during the qualitative data collection process.

HVs, CHWs and other health personnel will collect community census data on an annual basis. For example, El Alto will collect census data in Senkata in 2003 and beginning in 2004 will add Atipiri and Cumaravi in 2005. Montero will follow a similar schedule of collecting census data among its communities. (Census activities are a regular part of the CBIO methodology.

Verbal autopsy studies (based upon a previously-developed and tested methodology) will be routinely conducted at the household level to assess the causes of neonatal, child and maternal deaths (including barriers to care). Separate questionnaires for women and preschool children have been developed and will be used by CHWs and HVs during home visits to the families of children and women who have recently died. These questionnaires have been developed to look for not only medically related causes, but also social, cultural and mental causes.

Midterm and final evaluations will also collect data using a KPC survey and LQAS. Midterm and final levels of all key project indicators will be compared to baseline levels to determine the results of the project.

Analysis of Data

Information Analysis Committee (CAI) meetings are attended by representatives from the district MOH, community representatives and leaders, and all key levels of CSRA personnel

(CHWs, HVs, Field Coordinator, Program managers, and MOH physicians and nurses) will be held on a monthly basis at project sites. The committees will meet to review monthly program activities and data and plan activities for the following month. While CSRA senior field staff will be present, CHWs and HVs along with respective community participants will assume more of a leadership role during these meetings. The expanded CBIO approach will ensure a participatory process and one in which decisions are made through consensus and based on health information and program results. The project will also conduct data analysis workshops every three months with all field personnel at each site to serve as an evaluation of activities. Additionally, the project plans to hold annual workshops at each site to discuss causes of mortality within each project site with local authorities and community leaders. During this time, results of verbal autopsies will also be shared among workshop participants. Finally, annual work planning workshops will take place to review health data and plan activities for the upcoming year. These activities have been conducted in the past in our other project sites, and contributed greatly to our effectiveness in lowering mortality.

Methodologies to Improve Health Service Quality

Quality assurance standards that focus on improving health personnel case management skills will facilitate health service quality improvement. Patient satisfaction surveys at the household and health center level will be utilized to assess quality of health services. Health worker and volunteer performance will be strengthened through a process of accompaniment during home and health visits by both CSRA and MOH personnel. Monthly CAI meetings will also provide an effective means to mobilize and motivate HVs and CHWs to offer quality health services to respective communities[5].

[5] The project will not conduct any operational research.

Summary of Baseline and Other Assessments

Brief Description of Baseline Survey

A KPC survey was carried in El Alto and Montero using LQAS during December 2002, and January and February 2003. The baseline assessments included both quantitative methods (e.g., the KPC survey), and qualitative methods such as focus group discussions and in-depth interviews of specific informants. Focus group discussions were conducted to obtain complementary information that provided project managers with information regarding the attitudes, current beliefs and perceptions of targeted beneficiaries on specific subjects. During the focus groups, mothers and fathers with children under two were questioned separately. HVs in the area were also interviewed separately. Targets of in-depth interviews included current health personnel and local health officials, with representatives from the Vigilance Committee, and District and Mayor's offices. A detailed description was written by the survey's field coordinators that provide information regarding the methods, questionnaires and data analysis process of all assessment processes. (That description and questionnaires can be found in Annex F.)

Summary of Baseline Results

The baseline survey collected information about and the knowledge, practices, and coverage of mothers of young children in the project areas. Overall, the results were mixed with some areas that will need further attention, particularly in terms of *practices*, and other areas where some progress has already been made by the MOH. During the DIP preparation process, these baseline results were used by CSRA to re-evaluate the original proposed interventions in order to better identify areas that need further attention or reduce emphasis in areas that already have high coverage rates. Targets and benchmarks were also set using these baseline results. Significant differences between the two project areas exist in most of the indicators, and may be due to the amount of time that CSRA has already spent in Montero. Migration patterns also contribute to poor health status as close follow-up of risky practices and illness and is difficult in people who might leave the area and new immigrates might not be familiar with local health services. Overall, indicators from these peri-urban areas show better results than in CSRA's previous rural sites. The following is a summary of the results from the key intervention areas of the project.

Immunization

Generally, in regards to vaccination coverage rates, Montero has better outcomes then El Alto, which may be due to a more established CSRA presence in the Montero area. Infant health cards (either found with the mother or at the health center) were used to verify vaccination coverage. Complete immunization of children between 12 and 23 months was markedly different between the two project areas. For example, Montero's coverage was 67% while El Alto was only 30%. Coverage rates for children 12 to 23 months who were fully vaccinated before 13 months were low for both areas (El Alto 18% and Montero 33%). Individual vaccine coverage information was also gathered in each area. For example, the percent of children who had received a full dose of BCG was 82% and 97.8% in Montero and El Alto respectfully. The proportion of children 12 to 23 months who received the third dose of polio was different between the two sites (El Alto, 60% and Montero 91%). The percent of children who received the first dose of DPT was 89% in El Alto and 97.8% in Montero. Finally, measles coverage was only 38% in El Alto and 73% in Montero for children in the 12-23 month age group. Mother's knowledge of the

complete immunization scheme was also low and fairly similar in both sites (El Alto 31% and Montero 30%).

Nutrition and Micronutrients

The availability of an infant and or child health card at home or in the health center was 55% in El Alto and 80% in Montero. This card along with health center information verifies if vaccinations and growth monitoring are being completed on a timely basis. Overall, 40% of children in El Alto and 23% of children in Montero had a low birth weight. Growth monitoring in the first month of life was 56% in El Alto and 41% in Montero. Data was collected on children who were at *risk* of being malnourished (WAZ<-1) and malnourished (underweight, WAZ<-2). The study found that 10% of children in El Alto and 11% of children in Montero had weight-for-age Z-scores below
-2.

Given the importance of vitamin A in reducing childhood mortality, data was also collected to determine the rate of children who received a dose of vitamin A in the last six months. In El Alto less than half (46%) of children had received a dose of vitamin A while 66% of children in Montero received supplements. Project staff members recognize the significance of immediate breastfeeding on the health and nutritional status of newborn infants. Baseline results revealed that only slightly more then a third (39%) of infants in El Alto received breastfeeding within one hour of birth. In Montero, 54% of children received immediate breastfeeding. While immediate breastfeeding data was collected, exclusive breastfeeding rates, which are consistently high in both project areas, were not included in the baseline report.

Control of Diarrheal Disease

The rate of use of for oral rehydration solution (ORS) and/or other home-based fluids for children who had have diarrhea in the last two weeks was below half in both sites: 36% in El Alto and 42% in Montero). Information was also collected in the KPC regarding how children were fed when they had diarrhea. Mothers were asked if solid foods, liquids and/or breastfeeding was given more then usual, as usual, less then usual, or ceased completely. The percent of children less then 2 years with diarrhea who received the same amount or more of solid foods was 40% in Montero and 49% in El Alto. Mothers were also asked to cite danger signs that indicate that their child needs treatment. Results show very few mothers -- only 24% in El Alto and 34% in Montero -- were able to cite two or more of these danger signs. Mothers were also questioned about their hand-washing behavior. Mothers were asked if they had washed their hands with soap and water prior to cooking and feeding their children and after defecting. Results reveal an extremely low number of mothers (5% in El Alto and 3.5%) in Montero who practice hand-washing behavior.

Pneumonia Case Management

The percent of children 12 to 23 months of age who had difficult breathing (a sign of pneumonia) in the last two weeks was fairly low: only 12% in El Alto and 3.8% in Montero of the children had symptoms in the last two weeks. The mother's health care seeking behavior was also captured by the KPC: 41% of mothers in El Alto and 9% of mothers in Montero sought care for their child with rapid or difficult breathing from a trained health professional.

Maternal and Newborn Care

Mothers who received at least one prenatal control during their last pregnancy was high in both areas with 67% of mothers in El Alto and 92% in Montero receiving care. The proportion of mothers who received at least one dose of TT during her last pregnancy was reported in the KPC report, but existing MOH practices states that a woman should have least two doses at the time of her pregnancy, regardless of the doses she had received prior to pregnancy. For this indicator, the MOH norm in collecting information was not followed. It was difficult to verify TT coverage due to a low number of maternal health cards at visited households. The project now proposes to follow the MOH practice and record at least two doses of TT in the last pregnancy. Data on this indicator will be collected using a mini-survey so that targets can be adjusted. While information regarding full coverage (at least five doses) with TT was not collected in the baseline KPC, the project now proposes to gather information regarding the percent of women age 20 to 24 years who have received the complete series of TT. A Review of maternal health cards and facility records will be undertaken in 2003. If no information is available, the baseline level will be assumed to be zero. If some information is available, then a mini-survey will be conducted to verify results and establish a baseline level.

There was a huge difference in mothers who were attended by trained health care professional during delivery. For example, in Montero 88% of mothers received care by a trained person while less than half (47%) of mothers in El Alto received care by a trained person during delivery. This difference might be due to the amount of time that CSRA has already spent in Montero. Mother's knowledge of maternal danger signs during the postpartum period and in newborn children was extremely low for both areas. The recognition of danger signs during the postpartum period was 3.2% in El Alto and 5.3% in Montero while knowledge of danger signs in the newborn was 8% in El Alto and 7% in Montero for mothers. The percentage of mothers who receive a dose of vitamin A during the postpartum period was also low (18% in El Alto and 25% in Montero).

Finally, women were also questioned during the baseline KPC about the desire to have children and current birth spacing practices. The majority of mothers (86% in El Alto and 89% in Montero) with children 12 to 23 months expressed no desire to have more children. When mothers excluding those who were currently pregnant were asked about the use of modern birth control methods, it was found that only 21% of women in El Alto and 44% of women in Montero use any form of modern birth control. About a third of mothers with children less than two years of age are practicing birth spacing of less then 24 months (El Alto 35% and Montero 315%).

General Results from In-depth interviews and focus group discussions

Discussions with fathers and mothers of children less then two years revealed that both parents recognize the importance of regular growth monitoring activities for their children. In contrast, they also feel that food preparation and buying practices are unduly affected by factors out of their control such as economic conditions and work schedules. There does not seem to be a defined parent who makes health care decisions in the family. This depends more upon who is with the child in time of sickness. In both areas, there were no strong perceptions of the existence of economical or geographical barriers to access to services. There were, however, several principle reasons for dissatisfaction with healthcare services. Both mothers and fathers feel that poor service, lack of availability of essential drugs and supplies, perceived

discrimination, lack of Quechua language ability of health personnel, and wait time at health facilities were things that they felt needed additional attention.

Health volunteers were also interviewed and overall, there was a good level of motivation among those who participated in the group discussions. All groups however, particularily in El Alto, expressed a desire to have additional non-economic incentives such as training sessions in other subjects of interest. They identified subjects such as life saving skills and the administration of basic drugs and vaccines and expressed expectations to receive better recognition and support from the community authorities.

Program Description by Objectives, Intervention and Activities

Project's Goal and Objectives

The project's overall goal is to reduce child and maternal deaths and morbidity, with a focus on improving maternal, neonatal and infant health care services in the selected areas. This goal is consistent with USAID Bolivia's mission strategic objective of "improved health of the Bolivian population."

The project's general objectives are:

1. To strengthen community support through the training of CHWs and HVs, and increase access to child survival services through home visits and clinical consultations.
2. To increase demand for health prevention and treatment services through health education, community-based IMCI, and community maternal and neonatal health care strategies.
3. Increase the capacity of CSRA, municipal governments and the MOH to successfully plan, budget, implement and evaluate sustainable community child survival services.

The first general objective directly supports the USAID mission's Intermediate Result (IR) two – " improved quality and increased coverage of community health care by local governments"— by the training of CHWs and HVs to conduct home visits and lead group health educational meetings. The mission's IR1 –" improved child survival and reproductive and sexual health practices of individuals" –is consistent with the project's second general objective. Finally, USAID's IR3, "a decentralized and participatory health care system" is addressed by the project's third general objective. Specific intervention objectives will be described below.

Program Approaches and Strategies

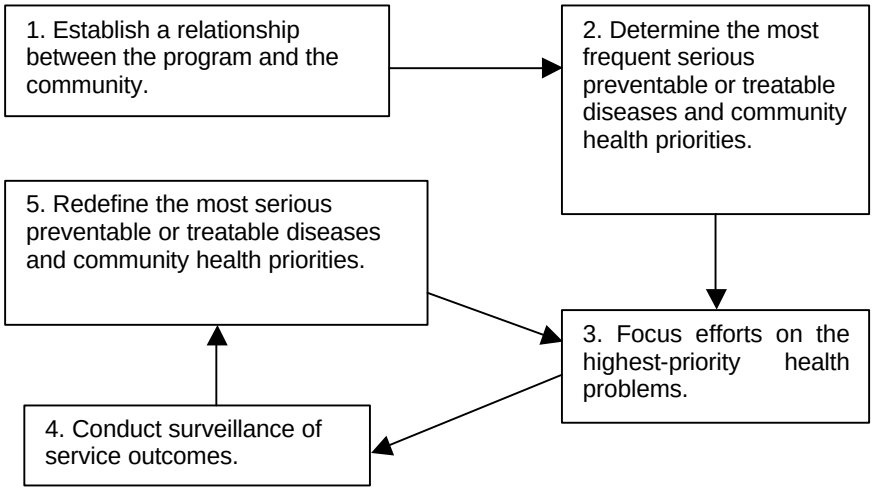
The project proposes to utilize several program approaches in order to address the principle interventions in both geographic areas.

Census Based Impact Orientation

CSRA and Curamericas have been applying the Census-Based, Impacted Oriented (CBIO) methodology in Bolivia for more then ten years. The model employs community health workers and health volunteers who carry out a program of home visits, preventive education and community surveillance activities that gather data on health status, current diseases, births, deaths and migration. Health care is also offered to community members in local health centers and through referrals to nearby area hospitals. This approach allows CSRA and Curamericas to target those at greatest risk of illness and death and focus program resources on resolving health programs at the household and community level.

The implementation of the CBIO approach involves several steps (also diagramed below): conducting a census and health assessment of the project area; drawing maps and numbering households; establishing family health folds; developing a program plan with community members that includes both health objectives as well as community perceived health need priorities; conducting targeted home visits in the service areas by health workers and volunteers to serve their own communities; the use of a health information system that allows program staff to track service delivery and vital events by household; and, multiple locations for service delivery[6]

The Census-Based, Impact-Oriented Approach



Since the proposal submission, CSRA has expanded the CBIO approach to further elaborate the role of the community in the design, planning, implementation and evaluation of health activities in the target areas. For example, during the initial assessment of community health problems, community leaders will be more integrated into project activities and focus not just on health issues but examine other external conditions such as availability of clean drinking water and waste disposal facilities that may impact the community's health status. Community members

[6] H. Perry, 1999. "Attaining Health for All through Community Partnerships: Principles of the Census-Based, Impact-Orientated (CBIO) Approach to Primary Health Care Developed in Bolivia, South America" *Social Science and Medicine 48: 1053-67*.

will also actively participate in the tabulation of health indicators during monthly meetings of the CAI so that they better understand the healthcare needs of their constituents. CAI is a community level committee that meets to analyze health data and report and discuss information collected by the MOH system. The outputs of this process is a prioritized list of health problems that can help guide community leaders to plan services and activities and help facilitate efficient local resource use. During the planning process community leaders and HVs will participate in the development of strategies to address priorities and follow-up strategies of high-risk cases. Once planning activities have been conducted, community members and leaders will actively participate and assume the responsibility to implement activities and define a routine monitoring system. Finally, community leaders and members and HVs will also participate in project led evaluation activities.

The CSRA and Curamericas community surveillance system consists of key data on service coverage (e.g., vaccines and vitamin A), growth monitoring, reported or observed illnesses, basic vital statistics and the treatments offered and recommended. This information is collected during routine home visits conducted by CHWs and HVs. This information will be routinely recorded in a basic registry that is carried to the household and maintained by each HV. Family health files, located at health centers, are also maintained for all community households in project areas. Colored flags on the files are used to denote households with certain conditions to track and follow-up on children who are malnourished or have diarrhea or respiratory infections, and on women identified with problems during pregnancy. This information, along with household level data, is routinely submitted to local MOH officials and will also be disseminated at community and CAI meetings (additional information regarding the community surveillance system will be discussed in Section D).

Integrated Management of Childhood Illnesses Strategy

The project will be implementing both the clinical and community components of the Integrated Management of Childhood Illness (IMCI) strategy in both project sites. Currently, none of the components of IMCI have been introduced in either area. CSRA is currently coordinating with PROCOSI, Bolivia's network of health and social development NGOs, on all IMCI-related activities to ensure that the project is following MOH norms and practices. PROCOSI, which is the coordinating organization for IMCI activities, is also providing valuable educational materials to Curamericas to help in the implemention of both components. Additionally, the MOH will be introducing new health educational materials in April 2003 for the community IMCI component.

Health personnel including CHWs (who are auxiliary nurses) and administrative staff, such receptionists who have direct contact with children will be trained in the clinical IMCI component. Signed agreements are in place that will allow for clinical IMCI trainings to take place at MOH training centers using MOH trainers. The MOH will also provide protocols and manuals for each participant. Based on the current Bolivian MOH guidelines for trainings, all clinical sessions will take five days and will include algorithms for children less then two weeks and children two months to five years of age. This seven-day training will incorporate the IMCI neonatal component. Follow-up activities will take place a month after training sessions to assess the level of retention and the need for refresher courses. CSRA and MOH personnel will use quality assurance tools to monitor and supervise IMCI implementation.

All personnel including HVs will also receive community IMCI training that focuses on an established list of twelve key behaviors. These behaviors identified and adapted by WHO and UNICEF, focus on physical growth and mental development, disease prevention, appropriate home care and care seeking behavior[7]. The MOH is currently validating modified guidelines for community-based IMCI that promises to incorporate additional aspects of promotion and prevention. MOH trainers will also initially lead trainings for community IMCI, but CSRA/Curamericas is currently negotiating with government officials to be able to hold trainings for trainer workshops so that CSRA staff can eventually facilitate and lead their own sessions in both geographic areas.

Based upon qualitative results of the baseline assessment, CSRA and Curamericas will be incorporating a cross-cultural program that will complement the IMCI strategy to bridge the gap between traditional practitioners and health personnel. The qualitative studies found evidence of cultural barriers, which affect quality of, and access to, services. The project staff members also felt that it was important to address the practices of traditional practitioners in order to have positive outcomes in areas where they are more common. In conjunction with TARI, CSRA is currently conducting a study of current beliefs and practices of traditional practitioners, community members and local government leaders in El Alto. Study results will be used to further modify interventions and develop a cross-cultural model that establishes open dialogue between cultures. The program will modify how staff conduct existing clinical protocols (e.g., the IMCI strategy) to emphasize changes in cross-cultural practices that consider the values and beliefs of the client and respect and encourage practices that do not harm health status. Through various training sessions and workshops, health personnel and local authorities will incorporate basic human rights principles in their work and also better understanding of cross-cultural practices particularly in the project's key intervention areas. During implementation of the cross-cultural model, the relationship between health personnel and traditional practitioners will also be strengthened particularly in El Alto. Specific activities conducted in the project's first year include: ensuring the adequacy of a culturally-appropriate environment and clinical protocols, cross-cultural training workshops for health personnel, local authorities, and other organized groups, and workshops among health personnel and traditional practitioners in order to share experiences and practices. Activities will first be implemented in El Alto; Montero will begin activities in the project's third year.

Quality Assurance

Results from in-depth interviews and focus group discussions during the baseline found that both men and women were dissatisfied with the quality of services found in their health centers and with the health personnel who serve them. CSRA and Curamerica's previous experience in improving quality has been further developed. A current pilot study of their quality assurance model is being implementing in a project site and will be completed by the end of December 2003. Results of this study will be analyzed and shared among project personnel. An expansion of the quality assurance model will begin in El Alto in January 2004. The model's implementation process involves three workshops that define quality assurance standards using existing instruments; present data collected by health personnel through simple tools; and develop an action plan that includes a monitoring system and a quality assurance team who will be in charge of improvements. The action plan also includes patient satisfaction surveys that will

[7] The Child Survival Technical Support Project. 2001. "Reaching Communities for Child Health and Nutrition: A Framework for Household and Community IMCI" Baltimore, Maryland.

be shared among the team in order to plan and prioritize additional activities that focus on areas that need further improvements. These action plans will be periodically monitored to ensure that standards are being met and follow-up activities will be conducted. (Additional information on the model and workshops can be found in Annex G).

The quality assurance program will be utilizing guides and formats that have been developed by the USAID-funded Quality Assurance Project (QAP). These guides will be used by the project personal, to create and develop standards and measurement tools. The quality assurance program will be implemented in all project sites and some standards and instruments of the program will be incorporated in the implementation of the IMCI strategy.

Quality improvements using QAP standards, instruments and technical assistance will also be implemented on an institutional level to build organizational capacity. The program will begin activities in June 2003. The program's primary objective is to improve the administrative services at project sites.

Supervision

To fully reach project objectives and targets, it is essential to have a well-defined supervision system in all project areas. This will ensure the optimal implementation of project strategies such as the IMCI approach for all key interventions. An effective supervision system will also facilitate the improvement of health personnel and health volunteer performance by providing timely feedback in all aspects of work responsibilities. Improved health worker performance will eventually led to better client satisfaction and better health outcomes.

During the first year of the project, central office personnel will refine the current supervision system. The improved system will be implemented in El Alto and Montero during the project's second year of operation. Routine monitoring and evaluation of the system will be performed at the beginning of the project's third year of implementation.

Quality assurance and supervision activities are intricately linked and are interchangeable in order to achieve the project's stated goals and objectives. For example, each quality assurance team will have a coordinator to ensure that standards are being met and improvements are continuous made and also to document experiences of team members. While individual performance will be monitored, the active participation of the whole team will be required in supervision activities. If poor results are present, the whole team will be involved in making improvements. Supervision and monitoring activities will also involve MOH level personnel.

Behavior Change Communication

The behavior change communication (BCC) strategy of this project is a central component of all project interventions and will strengthen the linkages between the community and health centers. Several indicators of knowledge and practice have been such as hand washing and knowledge of danger signs included in the project's evaluation system, which will measure the impact of the strategy. A newly employed Communication Manager will begin designing a new system for CSRA described briefly below in early April 2003.

The design and implementation of the project's BCC model consists of several steps, which rely on previously collected baseline information. Several activities in the primary assessment and analysis phase have already taken place. Those activities will establish the strategy's primary focus areas. During the baseline assessments, information was collected regarding current knowledge, attitudes and practices of mothers and fathers (who were consulted during focus

group discussions) of children under the age of two. The project staff will use this information to segment their target audiences and strengthening the attention received by children under the age of two and pregnant women. During the design of the BCC activities and materials, the project will identify and target other caretakers such as grandmothers, fathers and siblings. The BCC activities and materials will incorporate the norms and practices of the MOH. An evaluation of the current availability and costs of BCC materials and equipment will also take place.

The strategic design phase of the model will develop communication objectives that aim to strengthen knowledge and practices of caretakers and pregnant women. Based upon these objectives, strategies will be developed at various levels: individual, household, community and institutional. The model will use several programmatic methods described below and will also include health personnel training to improve services and design and implement policies.

As was stated in the proposal, CSRA will utilize several programmatic approaches and methodologies to improve current levels of knowledge and practices in all intervention areas. These program methodologies will complement the project's IMCI program and offer specific programmatic approaches that target particular intervention areas. For example, the (1) Process for the Promotion of Child Feeding (ProPan) program, which has been recently piloted in El Alto's Districts Two and Three by PAHO, WHO and the University of San Andres Mayor, (2) the Positive Deviant Approach developed by Save the Children and (3) Trials of Improved Practices (TIPS) methodologies will be utilized to improve infant and child nutritional practices. Finally, (4) CARE's Birth Plan methodology will be utilized to improve maternal and neonatal health practices. Overall, the project will use Barrier Analysis studies to determine the barriers that prevent people (e.g., mothers) from adopting appropriate behaviors and practices. The tool will be used with groups of mothers and fathers and also with the CHWs and HVs who are not correctly promoting key intervention activities. All of these programs will be described in detail under each individual intervention section. Below is a table that defines a schedule for the design and implementation of the CBC strategy:

Implementation Plan for the CBC Strategy

Activity	Year 1	Year 2	Year 3	Year 4	Year 5
Conduct an analysis and communication assessment	**X**				
Design BCC strategy	**X**				
Implement the BCC strategy		**X**			
Implement an integrated IMCI and BCC strategy		**X**			
Implement an integrated maternal health and BCC strategy	**X**				
Implement models (Barrier Analysis and Positive Deviance) to determine barriers and PD behaviors	**X**				
Implement other strategies of support at different levels		**X**	**X**	**X**	**X**
Conduct follow-up and monitoring activities	**X**	**X**	**X**	**X**	**X**
Conduct a mid-term and final evaluation			**X**		**X**

Program for Health Volunteers

Health volunteers play a significant role in the implementation of the CBIO methodology by conducting home visits and organizing community events for households in their area of responsibility. Their primary responsibilities include the conducting of home visits and annual censuses, community surveillance activities, leading and participating in organized community events and workshops, and playing an active role in CAI meetings. Through training sessions and active involvement at project level activities, CSRA HVs will have a basic understanding of important Bolivian laws (the Law of Popular Participation and Decentralization Law) and the MOH's health policies and programs (such as SUMI).

Currently, there are about 50 active HVs in Montero and only 8 active HVs in El Alto since the project is just beginning activities there. Both areas, however, have plans in place to expand their roster of HVs. For example, in Montero the ideal would be to have one HV for each block in a neighborhood in order to fully and effectively implement CBIO activities. Recruitment of volunteers will be conducted during coordination and informational sessions with community members in order to receive their input in the selection of persons that are known and valued. Recruitment criteria have been developed and will be revised and adjusted according to individual project sites.

El Alto will follow the following training schedule:

- 2003 36 volunteers for Senkata
- 2004 25 volunteers for Camaravi
- 2005 35 volunteers for Atipiri

The project has identified several specific objectives for the volunteer training program. It seeks to educate and promote a more humanized approach of health care delivery that offers cross-cultural aspects and implements BCC techniques in home visits and during organized community events. Volunteers will be trained to recognize and differentiate between various dangers signs in women and newborn infants and promote key health messages in the IMCI strategy. The volunteers will also have an opportunity to learn and implement the CBIO methodology and conduct census and community surveillance activities (e.g., the collection of vital events, risk cases, births and deaths) through regular home- and follow-up visits.

Specific training subjects and themes addressed in the cross-cultural training sessions include human rights, concepts and practices of both cultures, improving health services and traditional medicine. The IEC training will focus on how best to use educational materials to convey key messages and will also include Linkages materials and will apply the 'ORPA' process with mothers to create awareness and take action. The first step in the ORPA session is to 'observe' flip charts, drawings or pictures. The next step is to 'reflect' on the meaning of the visual aids. The following step is 'personalization', which includes talking about how each participant would behave in a similar situation. The final step is a discussion on the 'adoption' of ideal practices, which concludes by the facilitator presenting basic educational messages to the group. Other training topics will address improving key messages of the IMCI strategy and sessions on CBIO that focus on how to fill out forms and basic registers, and specific instructions on follow-up visits and referrals. Training sessions will be held every three months based on a previously

agreed upon schedule drafted by the HVs and health personnel. Sessions will be active and participatory in order to engage volunteers and increase retention of materials.

A supervisor will accompany HVs periodically to observe and offer feedback that that improves the technical and motivational level of volunteers. Every quarter volunteer activities and performance will be evaluated by other health personnel in conjunction with community members. Verification checklists and revisions of basic registers for quality control will be employed to ensure that vital events are recorded accurately, high-risk cases are detected and follow-up activities are performed on a timely basis. Local health board members and other local MOH authorities will also play a role in monitoring HVs on an annual basis.

The project staff members will develop an incentive program to address motivation and retention of volunteers. Some initial ideas include additional training sessions that focus on personal growth and development, the establishment of credentials that are recognized by the health network, certificates of participation in workshops and training sessions, donation of necessary educational materials and annual retreats. In Montero, HVs will be given a 50% discount in the provision of health services and essential medicines. An annual prize, selected by health center officials and community leaders will also be awarded to the five best HVs.

Descriptions of Key Interventions

Immunization

The project's primary objective for the immunization intervention includes increasing the number of children age 12 to 23 months who are completely vaccinated before they are 13 months old. This will be achieved by providing routine immunizations services at all health centers and during home visits. A mobile health unit will also conduct immunization sessions in communities that are located far from health centers. In order to increase coverage and change behavior, CHWs and HVs will provide promotional materials about immunizations during routine home visits and in sessions with organized groups such as mothers club meetings, parents meetings at local schools and other community events. Based on previous experience, CHWs should be able to provide complete immunization coverage to children by 13 months of age through four to five visits to the home or clinic. If a child is sick or not at home when a CHW is conducting a home visit, the session will be rescheduled in the near future. Newborn infants and children will be tracked though the community census in order to provide the complete series of recommended vaccines during home visits. The project will also participate in MOH sponsored vaccination campaigns when resources and personnel are available.

Data from home visits and health centers will be collected via infant and child health cards, which are supplied by the MOH to record growth monitoring and vaccination status of each child. Quite frequently these cards are in short supply, so CSRA also prints cards for their target households and health centers. Both the family and the CHW assigned to the particular community will have a copy of cards for the household. All information regarding the child's immunization status is recorded by the CHW or HV during home and clinic visits. The family health file maintained in the health center will also record immunization status of all children. A list of children by community who need to be vaccinated will be regularly updated to reduce dropouts or missed opportunities. Dropouts or missed opportunities are high in areas of high migration, such as Montero, and will require additional personnel to conduct follow-up activities. The CBIO approach will also ensure that all children receive their vaccinations on a timely basis. The clinical and community based components of IMCI will also be followed to reduce lost opportunities.

<u>MOH Norms and Practices</u>

Bolivia's MOH follows the WHO's guidelines for the complete Expanded Program of Immunizations (EPI) II for all infants 0 to 12 months of age and follows the schedule shown below[8] (the only exception is that WHO recommends Measles at 9 months):

[8] Ministerio de Salud y Prevision Social. November 2002. *Atencion integrada a las enfermedades prevalentes de la infancia (AIEPI) cuadro de procedimientos.* La Paz, Bolivia.

Age	Vaccine
New Borne	BCG
2 Months	Polio and Pentavalente (Hib, Hepatitis B plus DPT)
4 Months	Polio and Pentavalente (Hib, Hepatitis B plus DPT)
6 Months	Polio and Pentavalente (Hib, Hepatitis B plus DPT)
12 Months	Measles or MMR* (Measles, Mumps and Rubella)

* When supplies are available.

The MOH goal is to provide coverage to 80% of the population they serve. The project will follow all MOH immunization guidelines and protocols as stated above and will target children 0 to 12 months of age.

Behavior Change Communication

Baseline results from focus group discussions reveal that some mothers and fathers in Montero generally accept the reactions from various vaccinations. Families overall, however, particularly in El Alto, continue to deny vaccinations for their children due to beliefs that the injections cause illness and death, or for religious reasons. In order to increase the proportion of children age 12 to 23 months of age with complete vaccination coverage, several BCC activities will be carried out in the project to improve parent's knowledge and care seeking behavior, and to alter attitudes and beliefs of immunization services. For example, community IMCI training sessions will focus on improving the counseling skills on CHWs and HVs so that immunization services are effectively promoted. In addition to home visits, mass media techniques such as TV commercials or and radio spots will be employed as promotional tools in order to encourage parents to obtain the full series of immunizations for their infants and to influence community acceptance of child vaccination. The project will also utilize health fairs and other community events in schools and youth centers to promote the immunization program. These techniques

recommended age for full vaccination (by 13 months of age).

Barrier Analysis, a rapid qualitative tool, will be used to determine barriers to behavior change through a quick assessment of current perceptions. This information will be used to refine and develop new educational materials to correspond with barriers mothers often face in taking preventive action in order to reach the targeted beneficiaries. (This method is currently being examined by the CORE Behavior Change Working Group as a tool that may be applicable in other countries.) Barrier Analysis will be used in other intervention areas and will address the following barriers to taking preventive action:

- Low perceived susceptibility to the illness or problem
- Low perceived severity of the illness or problem
- Low perceived efficacy of the preventive action
- Perception of problematic social norms

- Perceived self efficacy (including lack of time and money)
- Lack of cues for action
- Perceived divine will
- Other positive and negative attributes of the action

Quality Assurance

The project will follow QAP's standard that calls for all health personnel at health centers to complete a 100% of all the required steps in the IMCI approach. The IMCI protocol asks health personnel to determine the status of an infant's vaccination status by reviewing the infant health card during the classification phase of the child's visit. In order to verify this standard, supervisory checklists developed by WHO will be employed in health centers and during home visits. The checklist is an observational supervisory tool that has been developed to check vaccination technique. In addition, field supervisors will provide periodic assessments of the overall immunization program. Field supervisors and site coordinators will be responsible for conducting follow-up monitoring activities and completing the checklists on a routine basis. The maintenance of the health cards will also be monitored by field supervisors through regular home visits and health center checks to determine if the dual recording system is current and accurate.

Availability of Supplies and Equipment

Most immunization supplies and all recommended vaccinations are currently either being provided by the MOH or the SUMI program. For example, the ministerial program is providing essential immunization supplies such as infant and child health cards, iceboxes, ice packs, and vaccines for both health centers and home visits. In the present case of Montero, however, only vaccines are being supplied by the MOH as no signed agreement is in place with municipality authorities. Negotiations with the local MOH and municipal officials are ongoing and the project hopes to have a signed agreement with officials and join the SUMI in 2003. In general, however, the MOH does not provide supplies such as syringes, alcohol and cotton balls. Those items will need to be supplied by either the SUMI or CSRA when supplies are not available.

In El Alto, equipment such as a refrigerator will be maintained by the mayor's office (as stated in the signed agreement between the MOH and CSRA). Cold chain maintenance will be conducted by health personnel and closely supervised by the quality team in all health centers in Montero. WHO standards will be followed to maintain and track proper temperature for vaccine preservation. The staff will receive safety training about blood-borne infections and the proper sterilization of equipment, individual use of syringes and needles, and proper handling of equipment. The supervision team in both areas will monitor safety standards. John Snow's USAID-funded Deliver Project will be conducting a training session for CSRA personnel in a non-project site in 2003. This training will focus on supply and drug management and will facilitate the development of an administrative and logistics system. Additional training sessions in Montero and El Alto are being considered to allow personnel the opportunity to refine the administrative and logistic systems in project sites.

An initial HFA of essential drugs, supplies and equipment was conducted in all three centers in Montero in March 2003. Results from a verification checklist found that two of the three centers have the complete scheme of vaccinations in stock and sufficient supply of disposable syringes. The newly established health center of CLEM will be obtaining vaccines and other supplies such as disposable syringes in the second quarter of the project's first year. While all centers have some ice packages and boxes, only one center has a sufficient number in good working condition

that can service the target population during field visits. All centers have a functioning refrigerator with a thermometer inside for temperature control. Inspections of records established that temperatures were in the correct range. The newly constructed health center in El Alto is just beginning health activities in April 2003. They are expecting to receive essential drugs and supplies from MOH and cold chain equipment such a refrigerator from the Mayor's office.

In order to determine whether current supplies are sufficient in health centers, an average utilization rate of supplies and vaccinations will be calculated which will be based on historical cases at each center. A more elaborate health facility assessment developed by BASICS will be conducted during the second six months of the project's first year[9]. In addition to the availability of supplies and essential vaccines, the assessment will also examine the quality issues for supplies, personnel training and supervision and the recording of data in the health information system. The immunization status of infants and children will also be reviewed at the time of the study.

[9] http://www.basics.org/publications/pubs/hfa/hfa_toc.htm

Control of Diarrheal Disease

The project has several objectives that aim to improve the management and prevention of diarrheal disease. Specifically, the project will seek to increase the proportion of caretakers who recognize the early danger signs of dehydration in their children and also increase the proportion of caretakers who utilize oral rehydration solution (ORS), other home-available fluids, and solid food to manage diarrhea and prevent dehydration. Hand washing behavior, which can reduce the prevalence of diarrhea disease by a median of 35% will also be addressed as a preventive measure.[4] Diarrhea case management and prevention are well integrated in the project's CBIO approach and IMCI strategies and will be addressed during home and center visits. Immediate and exclusive breastfeeding (see nutrition section) are also practices that are effective in preventing diarrhea, and will be a focus for the project. According to USAID's Technical Reference Materials, diarrheal diseases are estimated to be associated with about 25% of all measles mortality. The project's immunization program will therefore also be a tool to reduce the mortality associated with diarrhea.[10] Finally, hygiene and a clean drinking water source are important contributors in the prevention of diarrhea episodes in a community and can reduce prevalence by 15-20%.[4] While this intervention is not officially a part of the child survival project, the regional office in Montero currently has a dedicated resource person who is distributing portable water systems to the communities in the area.

MOH Norms and Practices

The MOH guidelines and practices for the control of diarrheal disease follow the clinical and community IMCI protocols for children under five years. For example, during the classification stage, the health worker evaluates the child for certain signs such as sunken eyes, skin turgor and thirst to determine whether the child currently has diarrhea and defines his/her dehydration status. Classifications include: diarrhea with severe dehydration; diarrhea with dehydration; diarrhea without dehydration; persistent diarrhea with dehydration; persistent diarrhea without dehydration; and diarrhea with blood dysentery. S/he further determines the duration of diarrhea episode. Once classification of the case has been determined various treatment protocols are discussed with the caretaker. IMCI's recommended treatment protocols depend upon the age and severity of the incidence of diarrhea. There are currently three plans in place for the treatment of dehydration: Plan A for treating dehydration at home, Plan B for treatments using ORS and Plan C for immediate intravenous treatment of serious dehydration. All plans instruct the mother on the use and preparation of ORS to treat dehydration. Severe episodes that last more then 14 days are referred the center or clinic for intravenous therapy. In cases where there is blood present in the stool of the child, an antibiotic or antimicrobial such as Cotrimoxazol is given as a first line drug.[11] In the case of dysentery, the MOH recommends that the child return to the center in two days for a reassessment and follow-up case management. The child should be returned to the health facility if blood continues to be present in the stool and the child is having difficulty drinking. If there is persistent diarrhea with no dehydration, the child should return to the health center in 5 days. The MOH protocols also detail feeding recommendations for children with persistent diarrhea and recommend the provision of Vitamin A according to age of the child.

[10] USAID/GH/HIDN/Child Survival and Health Grants Program – Technical Reference Materials. October 2002.
[11] Ministerio de Salud y Prevision Social. November 2002. *Atencion integrada a las enfermedades prevalentes de la infancia (AIEPI) cuadro de procedimientos*. La Paz, Bolivia.

UNICEF's standard ORS formula is currently being packaged and distributed by Bolivian drug companies under the brand name of *Suero la Vida*. ORS packages are readily available at project health centers, MOH facilities, and local pharmacies. In Bolivia, flavored ORS packages are common but not distributed by the MOH. Average costs of *Suera la Vida* in private pharmacies costs about $.35 and make one liter of solution. Flavored package costs average twice as much as the non-flavored solutions[12].

Behavior Change Communication

The project seeks to change several key behaviors and practices in the control of diarrheal disease. It emphasizes proper hygiene by encouraging mothers to wash their hands with soap/ash and water before food preparation and feeding of children, and after defecation and attending to a child who has defecated. Mothers will be taught to recognize danger signs of dehydration including: sunken eyes; skin returns slowly when pinched; irritability and crying a lot; and drinking liquids desperately with a great deal of thirst.[13] CHWs and HVs will also counsel mothers and other caretakers on when to seek treatment from health personnel, encourage breastfeeding and the increased quantity and frequency of fluids and foods. Key practices that will be promoted include, but are not limited to:

- Continuing the breastfeeding of a child with diarrhea and increasing frequency and length of time at each feeding
- Continuing to give small amounts of food to a child with diarrhea (if not exclusively breastfeeding) and increase liquids
- Give ORS to children with moderate and/or severe case of dehydration
- Teach mothers and/or caretakers how to prepare, mix and administer ORS
- Promote proper hygiene and hand washing techniques at specified times
- Educate mothers on various danger signs of dehydration and when to seek treatment
- Give children one extra meal a day for a week following a diarrheal episode in order to promote catch-up growth

Proper preparation of ORS will be heavily promoted. In order to improve rehydration practices, CHWs and HVs will follow IMCI protocols and ask mothers to prepare ORS packages during home visits.

Quality Assurance

CHWs and HVs will initially receive community IMCI training and ongoing refresher courses in counseling skills, assessing children with diarrhea, recognition of danger signs and symptoms of dehydration and treatment protocols. Follow-up visits by the supervision team and MOH officials will be conducted in the month immediately after IMCI training.

The QAP standard that all health personnel complete 100% of all steps in the IMCI protocol will ensure that proper assessment, classification and treatment of diarrheal disease cases are conducted during home and center visits. Another QAP standard will be applied: all cases of diarrhea with dehydration will have a follow-up visit within one or two days of diagnosis to determine the status of the child. Mother's knowledge of danger signs of dehydration will be

[12] Ram, Sujata. January 2002. "*Estudio de Factibilidad de Mercado para Cuatro Productos de Salud en Bolivia*" Population Services International and PROSALUD. La Paz, Bolivia.
[13] Ministerio de Salud y Prevision Social. November 2002. AIEPI – Manual de Procedimientos para Agentes Comunitarios de Salud.

assessed during midterm and final evaluations. Health personnel in each area will analyze data from these standards on a monthly basis during staff meetings.

Availability of Supplies and Equipment

All health centers must be able to count on having 100% of all essential drugs and supplies for the IMCI strategy. In terms of the diarrhea case management this means that a sufficient amount of the first line antimicrobial, Cotrimoxazol is available in the center's pharmacy. A preliminary HFA conducted in Montero determined that health centers had a sufficient supply of antibiotics and antimicrobials. The health centers also had ORS packages available, which had been purchased by CSRA. Promotional materials on ORS use and preparation, however, are only available at two of the three centers. CSRA hopes to have an agreement in place with municipal officials in 2003 so that the SUMI program will provide essential drugs and supplies. In El Alto, as an agreement exists between the MOH and CSRA, the SUMI will provide essential medicines such as antibiotics and ORS packages.

Pneumonia Case Management

The project's objective for pneumonia case management is to increase the proportion of mothers seeking prompt treatment from trained health personnel for their children ages 0 to 23 months who have signs of pneumonia. In order to improve recognition of signs, the project staff members will also seek to improve knowledge among mothers in the signs and symptoms of pneumonia for chest in-drawing and rapid and/or difficult breathing. CHWs and other personnel will all receive the clinical IMCI training and HVs will also be included in community-based IMCI training sessions that include SCM for pneumonia prevention and control.

The project's key strategies for pneumonia case management include: training of CHWs and HVs in the proper assessment of pneumonia through the IMCI approach; identification of children through home visits, clinic visits, or via the mobile health unit; provision of diagnosis and treatment during home visits or at health centers; health education sessions on early recognition and prompt care seeking with families and community groups; and, immediate follow-up visits to children who are being treated for pneumonia.

MOH Norms and Practices

The project will follow the MOH protocols for pneumonia case management (which are based upon the WHO guidelines for the IMCI strategy). During home and health center visits, trained health workers will assess the symptoms and associated danger signs by asking the mother or other caretaker whether the child has had a cough and difficulty in breathing; the health worker will proceed to observe and listen to the child's breath sounds, and count his/her respirations for one minute. The health worker will then classify the child based upon whether the child has any general danger signs, a cough, difficult/rapid breathing, and/or chest in-drawing. A severe case of pneumonia will immediately receive the first dose of the appropriate first-line antibiotic (Cotrimoxazol) and will be urgently referred to the hospital for further treatment and observation. Even if respiration returns to normal, the five-day treatment is continued and the child should have another health center visit. A moderate case will receive Cotrimoxazol twice a day for five days and the mother will be asked to return with the child in two days for follow-up and additional control.

A separate IMCI protocol and algorithm also exists for infants 7 days to 2 months of age. Infants classified with severe bacterial infections are given the first dose of antibiotics intravenously if they are seen in a clinic and immediately referred to the hospital. A non-severe bacterial infection is treated in the home, but the mother is asked to return the infant to the health center in 2 days. Gentamicine and penicillin are used for these cases.

The IMCI protocol contains specific instructions on how to teach the mother to measure, administer and store oral medicines at home. The mother administers the first dose in front of the health worker, which allows the health worker to observe the practice. MOH policies allow for all CHWs to administer antibiotics after they have received the IMCI training, as long as they are routinely supervised.

If the child is classified as not having pneumonia, the mother will be asked to observe the child and return to the center in 5 days if the child shows any signs of pneumonia or any general

danger signs. The protocol recommends an increase in fluid intake and continuous cleaning of the nostril passageways[14].

Behavior Change Communication

Improving family and community practices is central in the prompt recognition and management of pneumonia infections in children. In order to improve practices, CHWs need to have the appropriate skills to assess, classify, treat and refer and counsel mothers. Both components of IMCI will address improving these skills for personnel in all geographic areas. As mentioned above, CHWs and HVs will receive counseling training regarding antibiotic use and home care of children in order to educate mothers on proper medicine use and storage. While this ensures effective home-based treatment, it also trains health personnel to only use antibiotics in children who require them and reduces over usage of antibiotics. Additional (brief) follow-up training sessions will be conducted every three months at each project site in order re-enforce these skills.

Any delay in recognition of danger signs and care seeking for pneumonia is detrimental and can cause a further decline in the child's health status and increase the risk of death. As a consequence, the project will focus on improving a caretaker's ability to recognize symptoms and danger signs early and then to promptly seek appropriate trained care. These include: fast or difficult breathing, a cough with fast breathing, child looks unwell and is not eating or drinking, lethargy or change in consciousness, vomiting everything and/or high fever. As more then 30% of pneumonia-related deaths occur within the first two months of life, the project will target messages about danger signs and care seeking specifically for newborns (0 to 2 months of age)[15]. Other important practices that will be targeted include compliance with drug treatment protocols, continued feeding and increased fluids during and immediately after illness.

Community-wide strategies will also be employed in the management and prevention of pneumonia. For example, CSRA has a strategic partnership in place to closely collaborate community-level activities with Freedom from Hunger's local Bolivian NGO, CRECER which is also expanding its programs to El Alto and Montero. CRECER will provide technical assistance and funding to establish a village banking network. While CRECER is a micro credit organization, its mandate does include a health education focus. Currently, though, they are not actively working in health. Based upon a Freedom from Hungry model, CRECER would like to incorporate health sessions into its village banking meetings. Currently, community level promoters manage the banking process and are expected to also conduct health education sessions. These promoters, however, are not health personnel and have no formal training. CRECER would like CSRA's active involvement in capacity building and encourages health personnel to periodically participate in village banking sessions in order to promote services and provide health sessions.

Quality Assurance

The QAP standards for the IMCI protocol will also be applied for pneumonia case management, and field supervisors will use verification checklists during follow-up visits. All cases of pneumonia will be followed-up within 2 days of classification by CHWs and this will be verified on a monthly basis by field supervisors.

[14] Ministerio de Salud y Prevision Social. November 2002. *Atencion integrada a las enfermedades prevalentes de la infancia (AIEPI) cuadro de procedimientos*. La Paz, Bolivia.
[15] USAID/GH/HIDN/Child Survival and Health Grants Program – Technical Reference Materials. October 2002

Currently, CSRA does not have a defined referral system in place. Bolivia's SUMI program however, has developed instruments and instructions for referrals and counter-referrals. District officials in Montero will be holding a training workshop for all personnel in the area in order to discuss problems and develop an action plan. CSRA understands that a signed agreement with the MOH and the referral facility is necessary and will be developing forms and an incentive program early in the project's implementation based upon an evaluation of current referral practices.

Availability of Supplies and Equipment

The availability of antibiotics at the time of Montero's HFA was good at all project health centers. Centers, however, did not have wristwatches to be able to effectively count respiration rates. All CHWs who do not yet have wristwatches with a second hand (necessary to count respirations) will be provided with one. El Alto will be receiving antibiotics from the SUMI program while Montero is obtaining their own supplies from the MOH's national center.

Nutrition and Micronutrients

CSRA and Curamericas' approach in nutrition and micronutrients focus on increasing growth monitoring sessions, the promotion of immediate and exclusive breastfeeding, home- and group-based nutritional counseling sessions and the provision of Vitamin A supplements every six months. Based upon previous experience, regardless of gender, children six months to two years are at greatest risk and children ages two to five years are at elevated risk for growth faltering. The prevalence of malnutrition is seasonal and most often occurs during the early summer, after food supplies have been consumed and before new crops is harvested, and varies depending upon the location and relative wealth of communities.

The project will use the clinical and community IMCI components and other programs such as the Positive Deviance approach, Trials for Improved Practices and PAHO's ProPan strategy for nutritional counseling and rehabilitation. Community level health education sessions during CRECER's village banking sessions will also be conducted. Implementation of the Positive Deviance and TIPS methodology will begin in 2004 in both areas. ProPan will be first implemented on a pilot base in El Alto and implementation will be further evaluated due to budget limitations. The methodology will be incorporated, however, in the IMCI and BCC strategies.

The ProPan approach was recently pilot tested in Districts Two and Three in El Alto and the first two phases have been completed. The methodology provides guidelines, procedures and necessary tools such as software to systemically plan an intervention program for improving infant and child feeding practices. The methodology includes four modules, which are implemented over a period of three months[16]:

- Module 1 – an initial assessment phase that is the application of quantitative and qualitative methods (market surveys, 24 –hour recall, semi-structured interviews, opportunistic observation, survey of health personnel, and food attributes exercise) to identify the specific dietary deficiencies in the local area and the practices that led to these deficiencies;
- Module 2 – users test the acceptability and feasibility of the recommendations resulting from the assessment during household behavior and recipe trials to increase nutritional value of foods normally consumed and available in the community;
- Module 3 – an intervention plan is developed based upon the most feasible recommendations that improve nutrition in the community and minimize barriers; and,
- Module 4 – a monitoring and evaluation plan is developed to assess the impact of the intervention.

<u>MOH Norms and Practices</u>

The MOH has adapted WHO's IMCI strategy to fit their own needs in the area of nutrition and micronutrients. The adaptation phase has already occurred and protocols are in place that address assessment, classification, and rehabilitation of children with malnutrition, and preventive measures such as growth monitoring/nutritional counseling. During clinical and community IMCI sessions, health workers assess the nutritional status of the child to determine the presence of malnutrition and anemia. The child exam consists of asking, looking and

[16] Pachon, H. et al. June 2002. *Improving Infant and Child Nutrition in El Alto Bolivia: Results Using the ProPan Methodology.* Pan American Health Organization, World Health Organization and Universidad Mayor de San Andres, La Paz, Bolivia.

touching the child to detect signs of malnutrition and anemia such as visible emaciation, bipedal edema, palmor pallor, and low weight-for-age. The child is classified into one of three categories: severe malnutrition or anemia, moderate level of malnutrition or anemia and no presence of malnutrition or anemia. Treatment protocols for children more then two months of age for each category are listed below:

Severe malnutrition or anemia:

- Administer Vitamin A
- Refer immediately to a rehabilitation hospital

Infants 7 days to 2 months of age are also referred urgently to the rehabilitation facility.

Moderate malnutrition or anemia:

- Evaluate diet and administer vitamin oil, iron supplements and mebendazol to reduce parasites and prevent anemia
- Conduct follow-up in the next five days if diet problems exist
- Recommend to the mother when to return (for malnutrition, return in 10 days) and when to return immediately (e.g., if the condition becomes worse)
- (Conduct an evaluation on development and other illnesses

Infants 7 days to 2 months are to receive additional breastfeeding sessions and mothers are discouraged from introducing other liquids. For dietary problems, mothers are asked to return to the health center, or health workers conduct home visits to evaluate feeding practices within two days of the initial assessment. If the child continues to lose weigh, then he/she is referred to a rehabilitation facility. In case of low weight, children are re-evaluated after 7 days of the initial session.

If no malnutrition or anemia is present:

- Evaluate diet if child is less then two years of age
- Conduct nutritional counseling depending upon the age of the child
- Administer Vitamin A, iron supplements and Mebendazol
- If there are diet problems then conduct follow-up in the next five days
- Conduct an evaluation on development and other illnesses

The physical development of the child is evaluated using the Nelson Ortiz scale, which is based upon a variety of criteria depending on the age. During this assessment, the child's head circumference, ability to grasp objects, hear and speak properly, and the child's social and personal contacts of the child are assessed.

Vitamin A Supplementation (received every 6 months and verified by the infant health card)

Age	Capsules of Vitamin A	
	200,000 IU	100,000 IU
6 to 11 months	½ capsule	1 capsule
12 months to < 5 years	1 capsule	2 capsules

Vitamin Oil Supplementation

Malnutrition Level	Vitamin Oil (1 flask = 450 ml)
Moderate	1 spoonful in food 3 times/day (1 flask for 30 days)
Serious (when reference is not possible)	1.5 spoonfuls in food 3 times/day (2 flasks for 30 days)

Mebendazol (500 mg, single dose) is administered at the health center to children more then two years of age.

The MOH also has developed dietary guidelines for children depending upon age. Based upon WHO's recommendations, the MOH has an exclusive breastfeeding policy for all children less then 6 months of age and continued breastfeeding and gradual complementary feeding of children between 6 to 8 months of age. Its policy recommends that breastfeeding and complementary feeding continue up to 11 months and gives feeding recommendations, which describe particular foods and quantities of food for children greater then one year of age.

The MOH's growth monitoring guidelines follow the IMCI protocol (see below). Unfortunately, CSRA staff members believe that the MOH does not currently have the ability to undertake the level of growth monitoring required by the protocol. According to CSRA personnel, this high frequency of activity is both unrealistic and will potentially drain limited health personnel resources given the current context. Therefore, the project will follow a modified growth monitoring schedule:

Growth Monitoring Schedule

IMCI Protocol		Project	
Children < 2 months	Every 2 weeks	Children < 2 months	Every 2 weeks
Children 2 months to 2 years	Every month	Children 2 to 6 months	Every month
		Children 6 months to 2 years	Every 2 months
Children 2 to 5 years	Every 3 months	Children 2 to 5 years	Every 4 months

Behavior Change Communication

Constraints at the community level include, but are not limited to: 1) families are not accustomed to diversifying their diet; 2) home deliveries are conducted by family members or friends; 3) a lack of infant and child health cards; and 4) inadequate breastfeeding and complementary feeding practices. In addition, women often leave their younger children with older siblings while they are at work, and usually this means that there is little food available to the child during the day. The diet of a weaning child in the project area usually consists of high-bulk, low-nutrient foods that are suitable for adults, but do not meet the nutritional needs of a growing child.

Health personnel, CHWs and HVs will be trained in growth monitoring, Vitamin supplementation and nutritional counseling, and will conduct follow-up visits of malnourished children according the MOH guidelines. Key practices that will be addressed during home visits and nutritional counseling sessions are: immediate breastfeeding within the first hour of birth and increased complementary feeding; regular growth monitoring and maintenance of the child health card; regular Vitamin A supplementation every 6 months; and, proper food selection and preparation techniques based on findings of the Positive Deviance study. (The practice of exclusive breastfeeding will also be encouraged but given already high rates in both project areas, this will not be a primary focus of the project.)

The Positive Deviance approach (tested in Bolivia by Save the Children) will be implemented by the project to improve nutritional status of malnourished children. The method identifies poor families with well-nourished children who can serve as examples, and identifies those behaviors (good foods/feeding practices, good care seeking, and good child care practices) that lead to good nutrition. Messages are developed based upon the positive behaviors exhibited by well-nourished children, and then promoted among other families in the community.

In addition to the Positive Deviance and ProPan methodologies, the project will also utilize the Trials of Improved Practices (TIPS) methodology to test feeding recommendations for feasibility and acceptability in order to improve key nutritional behaviors. Curamericas will provide guidance to CSRA staff on the use of TIPS so that they are able to develop an assessment and counseling guide on appropriate feeding recommendations. (Additional information on the project's training plan will be discussed in the Organizational Development section).

Quality Assurance

As stated earlier, the project will follow QAP standards that ensure that all health personnel complete 100% of the recommended steps of the IMCI protocol. Supervisor checklists and observational techniques will be used by the quality team to verify correct application of the IMCI protocol during home and center visits. Supervisors will also verify that follow-up visits by CHWs and HVs of moderate and severe cases of malnutrition have been conducted correctly and on a timely basis. During monthly staff meetings, relevant cases will be discussed so that lessons can be learned and key messages are reinforced. The project will also develop referral and counter-referral systems so that serious cases of malnutrition can receive rehabilitative services at nearby hospitals.

Availability of Supplies and Equipment

The SUMI program will supply vitamin oil, iron supplements and also medicines such as mebendazol. The MOH's national distribution center will provide vitamin A supplements. According to the preliminary HFA in Montero, all three centers have vitamin A supplements in stock. The minimum quantity of stock for each product will be calculated for each health center based on historical cases of malnutrition and anemia. Once a minimum stock has been established the project will follow QAP standards to have at 90% of the essential drugs and vitamins for the IMCI in health center pharmacies. According to the HFA in Montero, all centers have balances for adults. Centers only have one balance to conduct growth monitoring sessions for infants and children, which is not currently sufficient to conduct home visits. Currently, health centers do not have a vehicle in order to conduct referrals.

Maternal and Newborn Care

Women of reproductive age, 15 to 49 years of age, and infants up to 28 days of life will be the target population for the project's maternal and newborn care intervention. The project's objectives will seek to improve the number of women who seek prenatal care services from a trained healthcare professional and who receive at least two doses of Tetanus Toxoid (TT) in their last pregnancy. The project will also focus on improving complete TT coverage of women age 20 to 24 years of age in order to reach school age youth. While prenatal counseling is an important component, the project's main focus will be to reduce or eliminate neonatal deaths and pregnancy-related complications by increasing mothers' knowledge of danger signs in newborns and danger signs in women during the post partum period. Women's vitamin A supplementation status during the postpartum period will also be addressed, along with the importance of birth spacing.

The birth plan methodology used by CARE – along with the CBIO approach -- will be the primary instruments used to improve maternal health outcomes and prevent serious neonatal complications. This methodology will be introduced during the second year of the project with technical assistance and training administered by CARE Peru personnel. Birth plans will be individualized and will target all pregnant women in project areas. The plan will identify specific action steps that incorporate nutrition and counseling needs of the woman and also will contain specific personalized information regarding the delivery and care of the newborn including immediate and exclusive breastfeeding. The plan will specify the type of birth attendant that the mother has selected (either trained health care personnel or TBAs) and the delivery location desired. The plan will also contain an emergency plan (including plans for emergency transport) in the event of maternal or neonatal complications.

MOH Norms and Practices

The project staff members are in agreement with the MOH's norms for maternal and neonatal health care, which promote improved health outcomes through birth preparedness; community plans for emergency obstetric care; and, improved quality maternal health care. While the MOH policy is strongly oriented towards institutional deliveries, CSRA and Curamericas will support deliveries by skilled health workers in the home as well as in health centers. The MOH will allow this variance of policy in the project areas.

The MOH's IMCI protocols also include various recommendations for maternal health. For example, if the mother is sick during a home or center visit, she is offered treatment or referred to the hospital. Women experiencing problems of breastfeeding such as infection, pain or lack of milk are given treatment and counseling. The woman is encouraged to maintain her own health and nutrition by increasing food and liquids during breastfeeding and also asked about TT status and given counseling on reproductive and STI/HIV/AIDs prevention. MOH's norms specify that the mother should receive vitamin A supplementation (200,000 UI) during the post partum period.

The MOH's norms and actual practice concerning TT differ. According to the CLAP, which are a series of forms that record MOH practices, a women should receive at least two doses of TT in her last pregnancy. These amounts can include any dose given prior to the pregnancy and the second dose given during the pregnancy. The MOH's national norm, however, says that pregnant women should receive at least two doses during her last pregnancy regardless of her

status prior to the pregnancy. The norm excludes women who have already received the complete or five doses of TT. Due to problems of verification of women who did not have a maternal health card, the project's baseline study only collected information about one dose of TT. It will now follow the MOH's norm and collect information about 2 doses of TT in the last pregnancy. Maternal health cards will also be distributed during home and mobile health unit visits so that accurate verification of TT can be conducted.

Behavior Change Communication

Both CHWs and HVs will receive training in reproductive health counseling skills and effective teaching techniques to improve attitudes and behaviors of women and other family members. Their training program will target interventions that reduce risks such as birth preparedness, birth plan development and follow-up, effective promotion of safe birthing kits, proper newborn care including immediate and exclusive breastfeeding and Vitamin A supplementation. CWHs and HVs will refer pregnant women to the health centers for antenatal controls and additional counseling sessions that have been included in their birth plans.

Baseline results revealed that women's knowledge of maternal danger signs during the postpartum period, and in their newborns, are alarmingly low. Mother's will be counseled about the dangers of infections (i.e., keeping the umbilical cord clean) and factors and danger signs for complications. Mass media techniques such as radio spots and community-wide broadcasts during health fairs and other meetings will be used to increase knowledge about danger signs.

A majority of births in the project sites are conducted outside of health facilities, at home without the assistance of trained birth attendants. Women and their families resist institutional deliveries for a variety of reasons: their spouses do not want their partners to be seen by another male; women are timid and do not want their private parts revealed to a stranger; women and families are not aware of the social health insurance program and its benefits; and, health centers are perceived as being cold and do not have the warmth of a home. Many of these factors are based upon cultural beliefs and attitudes and will be addressed through the project's cross-cultural program. CHWs and HVs will also train and counsel male partners and other family members on safe delivery and proper care of the newborn. This includes (but is not limited to) tying, cutting and cleaning the umbilical cord, washing the baby and keeping it warm, the administration of Vitamin K, proper breastfeeding techniques, and placement of the baby to the breast. CSRA and Curamericas has also developed appropriate birthing kits and CHWs and HVs will promote the use of the kits among men and other family members who might attend births. These kits are provided at no cost to family expecting a child and will also be distributed to local traditional birth attendants.

Quality Assurance

The project will follow QAP standards for maternal health. For example, CHWs and HVs should record relevant information and data for all women 18 or more weeks pregnant during home or health facility prenatal visits. This information includes: general data, previous deliveries (including information regarding the number of present children), and general clinical data and health status of the women. Patient satisfaction surveys will be used to verify that at least 90% of pregnant women are happy with the services during home and health center visits. All health centers will also have 100% of the minimum stock (determined on a historical basis) of four modern family planning methods (the oral contraceptive pill, Depoprovera, condoms and IUDs).

The supervisory system will employ observational techniques and checklists to determine whether or not CHWs, HVs and other personnel are correctly conducting counseling, prenatal care, and other activities (e.g., birth plan development). Relevant cases will also be discussed during monthly staff meetings.

Availability of Supplies and Equipment

The MOH national center will provide Vitamin A supplements to both sites. Current MOH norms do not provide folic acid to women of reproductive age. Iron supplements and all medicines, supplies and equipment related to maternal or neonatal complications are provided by the SUMI program. Existing supplies of vitamin A and iron supplements are available in all three Montero sites. CSRA and Curamericas will be providing birth kits to pregnant women and traditional birth attendants in project areas. Currently, the project is constructing a maternal center, which will provide delivery services at one of their health centers in Montero. The newly constructed health center in El Alto will also provide maternal health services along with delivery facilities and will also include an office for a traditional healer.

Work Plan

Program GOAL: Reduce child and maternal deaths and morbidity, with a focus on improving maternal, neonatal, and infant health care services in the proposed project areas

Immunizations (10%)

Objective #1: Increase the number of children age 12 to 23 months with complete vaccination coverage

Indicators:
Indicator #1 – Percent of children 12 to 23 months of age who are fully immunized
Measurement Method: Annual Mini-survey beginning 2004 (LQAS) and mid-term and final evaluation surveys.

Major Activities	Yr 1	Yr 2	3	4	5	Personnel	Baseline / Target
Household							**Project**
Reach isolated children by mobile team serviced by doctor, nurse and technician	4 →	→	→	→	→	Doctor, nurse and technician	Baseline: 51.8% Target: 80.0%
Use child health register to systematically and routinely follow-up children who have not received all doses	8					CHWs and HVs	
Educate fathers about the importance of vaccinations		2 →	→	→	→	CHWs and HVs	
Community							
Community education and promotion of immunization services	4 →	→	→	→	→	Field supervisions, CHWs and HVs	
Plan and promote EPI in neighborhoods.	4 →	→	→	→	→	Field supervisions, CHWs and HVs	
Health Facility							
EPI activities promoted in the facilities.	4 →	→	→	→	→	Nurses and CHWs	
District						Field coordinators	
Coordinate with Health Board Directors to conduct promotional activities in neighborhoods, schools with parent meetings and youth centers.	6 →	→	→	→	→		

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Control of Diarrheal Disease (20%)

Objective #2: Increase the number of mothers who recognize danger signs of dehydration

Indicators:

Indicator #1 – Percent of mothers of children 12 to 23 months with diarrhea in the last two weeks with knowledge of at least two danger signs of dehydration that indicate the need for treatment

Measurement Method: Annual Mini-survey beginning 2004 (LQAS) and mid-term and final evaluation surveys.

Major Activities	Yr 1	Yr 2	3	4	5	Personnel	Baseline/Target
Household Educate and train caretakers about danger signs and key messages in home visits	6 →	→	→	→	→	CHWs and HVs	**Project** Baseline: 29.4% Target: 40.5%
Community Collaborate with and train pharmacists and other health providers to promote the use of ORS and increase of liquids for diarrhea control	6 →	→	→	→	→	Field Coordinator and Sub-Coordinator	
Monthly promotional activities in hard to reach neighborhoods by use of a mobile team		4 →	→	→	→	CHWs, nurses, and doctors	
Health Facility Educate and train caretakers about danger signs and key messages in health centers	6 →	→	→	→	→	CHWs, nurses, and doctors	
Have traditional healer at the center in El Alto participate in community IMCI training	4					IMCI manager	

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #3: Improve diarrhea case management in young children.

Indicators:

Indicator #1 – Percent of children 12 to 23 months of age who were offered equal or greater quantities of solid foods during an episode of diarrhea in the past two weeks

Measurement Method: Annual Mini-survey beginning 2004 (LQAS) and mid-term and final evaluation surveys.

Major Activities	Yr 1	Yr 2	3	4	5	Personnel	Baseline/Target
Household							
Trainings in community IMCI	4					IMCI manager and MOH trainers	**Project**
Educate and train caretakers about danger signs and key messages in home visits	6 →	→	→	→	→	CHWs and HVs	Baseline: 45.4% Target: 65.0%
Community							
Use of practical hands-on learning methods to illustrate proper food preparation practices will be demonstrated at community meetings and mother's club meetings	9 →	→	→	→	→	CHWs and HVs	
Coordinate activities with CRECER during village banking meetings	6 →	→	→	→	→	CHWs and HVs	
Health Facility							
Training in clinical IMCI	4					IMCI manager and MOH trainers	
Have traditional healer at the center in El Alto participate in community IMCI training	4					IMCI manager and MOH trainers	
District							
Formalize institutional coordination so that health personnel can participant and incorporate key messages in community organized meetings held by local government authorities	8					Field Coordinators	

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #3: Improve diarrhea case management in young children.

Indicators:

Indicator #2 – Percent of children 12 to 23 months of age who received ORS or recommended home available fluids during an episode of diarrhea in the past two weeks

Measurement Method: Annual Mini-survey beginning 2004 (LQAS) and mid-term and final evaluation surveys.

Major Activities	Yr 1	Yr 2	3	4	5	Personnel	Baseline/Target
Household							
Trainings in community IMCI	4					IMCI manager and MOH trainers	**Project**
Educate and train caretakers about danger signs and key messages in home visits	6 →	→	→	→	→	CHWs and HVs	Baseline: 60.8% Target: 70.0%
Community	6 →	→	→	→	→	CHWs and HVs	
Use of practical hands-on learning methods to illustrate proper ORS preparation practices will be demonstrated at community meetings and mother's club meetings							
Coordinate health education activities with CRECER during village banking meetings	6 →	→	→	→	→	Directors and supervisors	
Health Facility							
Training in clinical IMCI	4					IMCI manager and MOH trainers	
Have traditional healer at the center in El Alto participate in community IMCI training	4					IMCI manager and MOH trainers	
District							
Formalize institutional coordination so that health personnel can participant and incorporate key messages in community organized meetings held by local government authorities	8					Field Coordinators	

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #3: Improved hygiene practices in mothers of young children in order to decrease diarrheal prevalence

Indicators:

Indicator #3 – Percent of mothers with children 0 to 23 months of age who report they wash their hands with soap and water before food preparation, before feeding children, after defecation and after attending to a child who has defecated

Measurement Method: Annual Mini-survey beginning 2004 (LQAS) and mid-term and final evaluation surveys.

Major Activities	Yr 1	Yr 2	3	4	5	Personnel	Baseline/Target
Household							
Trainings in community IMCI	4					IMCI manager and MOH trainers	**Project**
Prioritize key educational messages with a focus on the new born during home visits	6 →	→	→	→	→	CHWs and HVs	Baseline: 4.4% Target: 30.0%
Community							
Use of practical hands-on learning methods to illustrate proper hand washing practices will be demonstrated at community meetings and mother's club meetings	6 →	→	→	→	→	CHWs and HVs	
Coordinate health education activities with CRECER during village banking meetings	6 →	→	→	→	→	Directors and supervisors	
Promotional activities using mass media such as broadcasts, local health fairs and announcements in the health center	5 →	→	→	→	→	CHWs, nurses, HVs, and other personnel	
Health Facility							
Training in clinical IMCI	4					IMCI manager and MOH trainers	
District							
Coordinate with teachers to include key educational messages in school activities	5 →	→	→	→	→	Field Coordinator and Sub-Coordinator	

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Pneumonia Case Management (20%)

Objective #4: Improve care seeking practices of mothers of young children with signs of pneumonia

Indicators:

Indicator #1 – – Percent of children 12 to 23 months of age who received treatment from a trained health personnel when they had cough and rapid/difficult breathing

Measurement Method: Annual Mini-survey beginning 2004 (LQAS) and mid-term and final evaluation surveys.

Major Activities	Yr 1	Yr 2	3	4	5	Personnel	Baseline/Target
Household							
Trainings in community IMCI	4					IMCI manager and MOH trainers	**Project**
Prioritize key educational messages for home visits	6 →	→	→	→	→	CHWs and HVs	Baseline: 37.6% Target: 50.0%
Surveillance activities during collection of vital event data	6 →	→	→	→	→		
Community							
Coordinate health education activities with CRECER during village banking meetings	6 →	→	→	→	→	CHWs and HVs	
Promotional activities using radio spots	6 →	→	→	→	→	CHWs and HVs	
Health Facility							
Training in clinical IMCI	4					IMCI manager and MOH trainers	
Ensure that essential drugs and supplies are available at the center							
Implement the IMCI supervision system	6					IMCI manager and Sub-coordinator	
District							
Design a referral system with the reference hospital and obtain a formal agreement	8 →	→	→	→	→	Field Coordinator and Sub-Coordinator	

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Nutrition and Micronutrients (25%)

Objective #5: Improve early intervention to prevent growth faltering of young children

Indicators:

Indicator #1 – Percent of children 0 to 23 months of age who are weighed during their first month of life

Measurement Method: Annual revision of infant health cards and compared to vital events data

Major Activities	Yr 1				Yr 2				3	4	5	Personnel	Baseline/Target
Household													
Trainings in community IMCI Training to health volunteers		4										IMCI manager	**Project**
Obtain birth records of recent births and conduct follow-up visits after the first week of birth		4	7	10	1	4	7	10	→	→	→	Nurses, CHWs and HVs	Baseline: 46.9% Target: 75.0%
Growth monitoring and nutritional counseling during home visits					2	→	→	→	→	→	→	CHWs and HVs	
Surveillance activities during collection of vital event data during home visits		6	→	→	→	→	→	→	→	→	→	CHWs and HVs	
Community		6	→	→	→	→	→	→	→	→	→	CHWs and HVs	
Use of Positive Deviance and TIPS methodology on proper food preparation and use					2	→	→	→	→	→	→	Nurses, CHWs and HVs	
Coordinate activities with CRECER during village banking meetings													
Establish a mobile team of 2 to 3 persons to conduct home visits and attend community events		6	→	→	→	→	→	→	→	→	→	CHWs and HVs	
Health Facility												Field Coordinator and Sub-Coordinator	
Growth monitoring and nutritional counseling in the clinic		6	→	→	→	→	→	→	→	→	→	Nurses, doctors and CHWs	

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #6: Improve nutritional status of young children

Indicators:

Indicator #1 – Percent of children 0 to 23 months of age who are below 2 standard deviations from the median weight for age

Measurement Method: Annual revision of infant health card

Major Activities	Yr 1				Yr 2				3	4	5	Personnel	Baseline/Target
Household													
Trainings in community IMCI	4											Nurses	**Project**
Training to health volunteers	4	7	10	1	4	7	10	→				CHWs and HVs	Baseline: 10.6% Target: 5.0%
Growth monitoring and nutritional counseling during home visits	6	→										CHWs and HVs	
Surveillance activities during collection of vital event data during home visits	6	→										Nurse supervisors, CHWs and HVs	
Follow-up activities on severe cases of malnutrition using individualized plans conducted every 15 days			10	→								CHWs and HVs	
Community													
Use of Positive Deviance and TIPS methodology on proper food preparation and use												CHWs and HVs	
Coordinate health education activities with CRECER during village banking meetings	6	→										Field Coordinator and Sub-Coordinator	
Establish a mobile team of 2 to 3 persons to conduct home visits and attend community events	6	→										Technical staff and Sub Director	
Establish a referral system including a information system for severe cases with agreements with local reference hospitals		8										Technical staff and Sub Director	
Health Facility													
Standardize a nutritional counseling protocols for health team and develop individual plans		7										Technical staff and Sub Director	

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #7: Increase the proportion of children 0 to 23 months who are immediately breastfed (during the first hour of birth)

Indicators:

Indicator #1 – Percent of children 0 to 23 months of age who receive immediate breastfeeding during the first hour of birth

Measurement Method: Annual revision of infant health card

Major Activities	Yr 1				Yr 2				3	4	5	Personnel	Baseline/Target
Household													
Training to health volunteers		4	7	10	1	4	7	10	→			Nurses	**Project**
Nutritional counseling during home visits		6	→									CHWs and HVs	Baseline: 46.0% Target: 67.5%
Implement Birth Plans with technical assistance from CARE					2	→						CHWs and HVs	
Community													
Use of Positive Deviance and TIPS methodology													
Coordinate health education activities with CRECER during village banking meetings		6	→									Nurse supervisors, CHWs and HVs	
Education of mothers and other family members during women's meetings and educational activities in schools and colleges		6	→									CHWs and HVs	
Promotional campaigns via mass media (community broadcasts, radio spots and health fairs)			8	→								Field Coordinator and Sub-Coordinator	
Health Facility													
Standardize a nutritional counseling protocols for health team and develop individual plans			7	10		4						Field Coordinator and Sub Coordinator	
District													
Coordinate with second level hospitals to organize training activities for health personnel			8									Field Coordinator and Sub Coordinator	

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #8: Increase the proportion of children 6 to 59 months of age who receive vitamin A supplements

Indicators:
Indicator #1 – Percent of children 6 to 59 months of age who receive vitamin A supplements in the last 6 months
Measurement Method: Annual revision of infant health card

Major Activities	Yr 1				Yr 2				3	4	5	Personnel	Baseline/Target
Household													
Training to health volunteers		4	7	10	1	4	7	10	→	→	→	Nurses	**Project**
Nutritional counseling during home visits		6	→	→	→	→	→	→	→	→	→	CHWs and HVs	Baseline: 55.6% Target: 80.0%
Surveillance activities during collection of vital event data during home visits		6	→	→	→	→	→	→	→	→	→	CHWs and HVs	
Community													
Establish a mobile team of 2 to 3 persons to conduct home visits and attend community events		6	9	12	2	5	9	12				Nurse supervisors, CHWs and HVs	
Participate in MOH vaccination campaigns		5											
Health Facility													
Regular dosing during clinic visits		5	→	→	→	→	→	→	→	→	→	Nurses and CHWs	
District													
Coordinate with the MOH to assure the timely supply of Vitamin A supplements for all centers and home visits		5	→	→	→	→	→	→	→	→	→	Field Coordinator	

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Maternal and Newborn Care (25%)

Objective #9: Increase the proportion of women who receive prenatal care services from a trained healthcare professional

Indicators:
Indicator #1 – Percent of mothers who have received at least one prenatal care visit in their last pregnancy
Measurement Method: Annual revision of maternal health cards compared to expected pregnancies following the Bolivian MOH and census data

Major Activities	Yr 1				Yr 2				3	4	5	Personnel	Baseline/Target
Household													
Training to health volunteers	4	7	10	1	4	7	10	→	→	→	→	Nurses	**Project**
Home visits to identify pregnant women and encourage them to seek services.	6	→	→	→	→	→	→	→	→	→	→	CHWs and HVs	Baseline: 81.6% Target: 90.0%
Surveillance activities during collection of vital event data during home visits	6	→	→	→	→	→	→	→	→	→	→	CHWs and HVs	
Community													
Education of mothers and other family members on the importance of prenatal care at community meetings, women's meetings and educational activities in schools and colleges	6	→	→	→	→	→	→	→	→	→	→	Nurse supervisors, CHWs and HVs	
Promotional campaigns via mass media (community broadcasts and health fairs)	5	→	→	→	→	→	→	→	→	→	→	Nurses and CHWs	
Coordinate with other organizations such as CRECER and PRO MUJER	4	→	→	→	→	→	→	→	→	→	→	Field Coordinator	
Health Facility													
Regular prenatal care services during clinic visits	4	→	→	→	→	→	→	→	→	→	→	Nurses and CHWs	
District													
Coordinate with Health Boards and MOH to promote prenatal care services	6	→	→	→	→	→	→	→	→	→	→	Field Coordinator	

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #10: Increase in the proportion of women who seek prenatal care services from a trained healthcare professional

Indicators:
Indicator #1 – Percent of women whose last pregnancy was attended by a trained health worker
Measurement Method: Annual mini-survey beginning October/November 2004 compared to the Bolivian MOH and vital events data

Major Activities	Yr 1				Yr 2				3	4	5	Personnel	Baseline/Target
Household													
Training to health volunteers		4	7	10	1	4	7	10	→	→	→	Nurses	**Project**
Home visits to identify pregnant women and encourage them to seek trained healthcare services.		6	→	→	→	→	→	→	→	→	→	CHWs and HVs	Baseline: 67.5% Target: 85.0%
Surveillance activities during collection of vital event data during home visits		6	→	→	→	→	→	→	→	→	→	CHWs and HVs	
Implement Birth Plans with technical assistance from CARE					2	→	→	→	→	→	→	Nurse supervisors, CHWs and HVs	
Community													
Education of mothers and other family members during women's meetings and educational activities in schools and colleges		5	→	→	→	→	→	→	→	→	→	Nurses and CHWs	
Promotional campaigns via mass media (community broadcasts and health fairs)		4	→	→	→	→	→	→	→	→	→	Nurses, CHWs and HVs	
Coordinate with other organizations such as CRECER and PRO MUJER		4	→	→	→	→	→	→	→	→	→	Field Coordinator	
Health Facility													
Regular maternal health services during clinic visits		6	→	→	→	→	→	→	→	→	→	Nurses, doctors and CHWs	
District													
Coordinate with Health Boards and MOH to promote delivery services		6	→	→	→	→	→	→	→	→	→	Field Coordinator	

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #11: Increase the proportion of women who are immunized against tetatnus

Indicators:

Indicator #1 – Percent of women who obtained at least 2 doses of tetanus toxoid during their last pregnancy

Measurement Method: Annual revision of maternal health cards compared to expected pregnancies following the Bolivian MOH and census data

Major Activities	Yr 1				Yr 2				3	4	5	Personnel	Baseline/Target
Household													
Training to health volunteers		4	7	10	1	4	7	10	→	→	→	Nurses	**Project**
Home visits to identify pregnant women and encourage them to seek services.		6	→	→	→	→	→	→	→	→	→	CHWs and HVs	Baseline: 69.4%* Target: 90.0%
Surveillance activities during collection of vital event data during home visits and maintenance of vaccination cards of all eligible pregnant women.		6	→	→	→	→	→	→	→	→	→	CHWs and HVs	
Implement Birth Plans with technical assistance from CARE					2	→	→	→	→	→	→	Nurse supervisors, CHWs and HVs	
Community													
Education of mothers and other family members during women's meetings and educational activities in schools and colleges		5	→	→	→	→	→	→	→	→	→	Nurses and CHWs	
Promotional campaigns via mass media (community broadcasts and health fairs)		4	→	→	→	→	→	→	→	→	→	Nurses, CHWs and HVs	
Coordinate with other organizations such as CRECER and PRO MUJER		4	→	→	→	→	→	→	→	→	→	Field Coordinator	
Health Facility													
Regular maternal health services during clinic visits		6	→	→	→	→	→	→	→	→	→	Nurses, doctors and CHWs	
District													
Coordinate with Health Boards and MOH to promote delivery services		6	→	→	→	→	→	→	→	→	→	Field Coordinator	

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

* The baseline line data only recorded women who have received at least one dose of TT in their last pregnancy.

Objective #12: Increase the proportion of women 20 to 24 years who receive the full series of tetanus toxoid

Indicators:

Indicator #1 – Percent of women 20 to 24 years of age who are fully vaccinated – 5 doses— of with tetanus toxoid

Measurement Method: For 2003 do a rapid assessment of health center registers in the area if data is available do a mini-survey to valid results and establish a baseline. Conduct a mid-term and evaluation survey.

Major Activities	Yr 1				Yr 2				3	4	5	Personnel	Baseline/Target
Household													
Training to health volunteers		4	7	10	1	4	7	10	→	→	→	Nurses	**Project**
Home visits to encourage them to seek services.		6	→	→	→	→	→	→	→	→	→	CHWs and HVs	Baseline: N/A* Target: ?
Surveillance activities during collection of vital event data during home visits and maintenance of vaccination cards of all eligible women.		6	→	→	→	→	→	→	→	→	→	CHWs and HVs	
Implement Birth Plans with technical assistance from CARE					2	→	→	→	→	→	→	Nurse supervisors, CHWs and HVs	
Community													
Education of mothers and other family members during women's meetings and educational activities in schools and colleges		5	→	→	→	→	→	→	→	→	→	Nurses and CHWs	
Promotional campaigns via mass media (community broadcasts and health fairs)		4	→	→	→	→	→	→	→	→	→	Nurses, CHWs and HVs	
Coordinate with other organizations such as CRECER and PRO MUJER and also with school principles and directors		4	→	→	→	→	→	→	→	→	→	Field Coordinator	
Health Facility													
Regular maternal health services during clinic visits		6	→	→	→	→	→	→	→	→	→	Nurses, doctors and CHWs	
District													
Coordinate with Health Boards and MOH to promote delivery services		6	→	→	→	→	→	→	→	→	→	Field Coordinator	

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

* Targets will be determined once baseline data is established.

Objective #13: Increase the proportion of women who are able to recognize danger signs in their newborn child.

Indicators:
Indicator #1 – Percent of women who can cite at least 2 danger signs in newborn children
Measurement Method: Annual Mini-survey beginning 2004 (LQAS) and mid-term and final evaluation surveys.

Major Activities	Yr 1				Yr 2				3	4	5	Personnel	Baseline/Target
Household													
Community IMCI training		4										IMCI manager	**Project**
Training to health volunteers		4	7	10	1	4	7	10				Nurses	Baseline: 7.2% Target: 40.0%
Home follow-up visits to encourage them to seek services		6	→	→	→	→	→	→	→	→	→	CHWs and HVs	
Surveillance activities during collection of vital event data during home visits and maintenance of vaccination cards of all eligible women.		6	→	→	→	→	→	→	→	→	→	Nurse supervisors, CHWs and HVs	
Implement Birth Plans with technical assistance from CARE					2	→	→	→	→	→	→	Nurses and CHWs	
Community													
Education of mothers and other family members during women's meetings and educational activities in schools and colleges		5	→	→	→	→	→	→	→	→	→	Nurses, CHWs and HVs	
Promotional campaigns via mass media (community broadcasts, radio spots and health fairs)		5	→	→	→	→	→	→	→	→	→	Field Coordinator	
Coordinate with other organizations such as CRECER and PRO MUJER and also with school principles and directors		4	→	→	→	→	→	→	→	→	→	Nurses, doctors and CHWs	
Health Facility													
Regular maternal health services during clinic visits		6	→	→	→	→	→	→	→	→	→	Field Coordinator	
District													
Coordinate with Health Boards and MOH to promote services		6	→	→	→	→	→	→	→	→	→		

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #14: Increase the proportion of women who are able to recognize maternal danger signs during the postpartum period

Indicators:
Indicator #1 – Percent of women who can cite at least two maternal danger signs during the postpartum period
Measurement Method: Annual Mini-survey beginning 2004 (LQAS) and mid-term and final evaluation surveys.

Major Activities	Yr 1				Yr 2				3	4	5	Personnel	Baseline/Target
Household													
Community IMCI training		4										IMCI manager	**Project**
Training to health volunteers		4	7	10	1				4	7	10	Nurses	Baseline: 4.2% Target: 40.0%
Home follow-up visits to encourage them to seek services		6 →									→	CHWs and HVs	
Surveillance activities during collection of vital event data during home visits and maintenance of vaccination cards of all eligible women		6 →									→	Nurse supervisors, CHWs and HVs	
Implement Birth Plans with technical assistance from CARE					2 →						→	Nurses and CHWs	
Community													
Education of mothers and other family members during women's meetings and educational activities in schools and colleges		5 →									→	Nurses, CHWs and HVs	
Promotional campaigns via mass media (community broadcasts, radio spots and health fairs)		5 →									→	Field Coordinator	
Coordinate with other organizations such as CRECER and PRO MUJER and also with school principles and directors		4 →									→	Nurses, doctors and CHWs	
Health Facility													
Regular maternal health services during clinic visits		6 →									→	Field Coordinator	
District													
Coordinate with Health Boards and MOH to promote services		6 →									→		

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #15: Increase the proportion of women who receive vitamin A supplementation in the postpartum period

Indicators:
Indicator #1 – Percent of women who receive vitamin A supplements during the postpartum period
Measurement Method: Annual Mini-survey beginning 2004 (LQAS) and mid-term and final evaluation surveys.

Major Activities	Yr 1				Yr 2				3	4	5	Personnel	Baseline/Target
Household													
Community IMCI training		4										IMCI manager	**Project**
Training to health volunteers		4	7	10	1				4	7	10	Nurses	Baseline: 21.4% Target: 80.0%
Home follow-up visits to administer Vitamin A		6 →									→	CHWs and HVs	
Surveillance activities during collection of vital event data during home visits and maintenance of vaccination cards of all eligible women		6 →									→	Nurse supervisors, CHWs and HVs	
Implement Birth Plans with technical assistance from CARE					2 →						→	Nurses and CHWs	
Community													
Education of mothers and other family members during women's meetings and educational activities in schools and colleges		5 →									→	Nurses, CHWs and HVs	
Promotional campaigns via mass media (community broadcasts, radio spots and health fairs)		5 →									→	Field Coordinator	
Coordinate with other organizations such as CRECER and PRO MUJER and also with school principles and directors		4 →									→	Nurses, doctors and CHWs	
Health Facility													
Regular maternal health services during clinic visits		6 →									→	Field Coordinator	
District													
Coordinate with Health Boards and MOH to promote services assure supplies		6 →									→		

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

IMCI

General Objective: Improve the quality of care offered to children under 5 years of age by implementing the IMCI strategy.

Objective #1: Introduce the IMCI strategy to the health personnel involved with the project

Indicators:

Indicator #1 – Number of meetings with health team to review and analyze the results of the IMCI standards of quality

Measurement Method: Review of the results of pretest and post-tests and meeting notes.

Major Activities	Yr 1				Yr 2				3	4	5	Personnel	Baseline/Target
Initial workshops to introduce the IMCI strategy and approach to health personnel in each area	1											IMCI manager	**Project** Baseline: 0 Target: 5
Organize follow-up teams and develop roles and responsibilities of each member													

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #2: Strengthen the IMCI operational capacity of health personnel (in terms of detection, classification, treatment, orientation and follow-up activities)

Indicators:

Indicator #1 – Percent of children under the age of five years who have been assessed using the IMCI approach

Measurement Method: Review of personnel files and workbooks and verification checklists

Major Activities	Yr 1				Yr 2				3	4	5	Personnel	Baseline/Target
Coordinate with municipality officials and MOH to establish IMCI training sessions at MOH training center	2-3											IMCI manager	**Project** Baseline: 0 Target: 90.0%
Develop training budget and negotiate for additional funding from other organizations	3											IMCI manager	
Analysis workshop with IMCI follow-up team to define and design home visits and clinic services	4											IMCI manager and IMCI team	
IMCI clinical training for health personnel in both areas	4											IMCI manager and MOH IMCI trainer	

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #2: Strengthen the IMCI operational capacity of health personnel (in terms of detection, classification, treatment, orientation and follow-up activities)

Indicators:

Indicator #2 – Percent of health personnel who able complete 90% score of applying standards of quality in clinic-based IMCI

Measurement Method: Review of instruments that measure quality standards verification checklists

Major Activities	Yr 1				Yr 2				3	4	5	Personnel	Baseline/Target
Implement Quality Assurance process in respect to IMCI	4											IMCI manager	**Project** Baseline: 0 Target: 90.0%
Train health personnel in follow-up activities and using quality assurance instruments	4	→	→	→	→	→	→	→	→	→	→		
Analysis workshop with IMCI to present relevant cases as a learning tool	4												
Conduct refresher courses		8		12		6		12	→	→	→		
Design an incentive system for health personnel who demonstrate correct IMCI application		8	→	→	→	→	→	→	→	→	→		
Meetings with IMCI team to evaluate progress especially in regards to the IMCI standards of quality		8	→	→	→	→	→	→	→	→			
Follow-up visits conducted by the IMCI manager to assess quality		5	8	12	1	4	8	12	→	→	→		

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #3: Strengthen the IMCI operational capacity of health personnel (in terms of detection, classification, treatment, orientation and follow-up activities)

Indicators:

Indicator #1 – Percent of pharmacies in health centers have at least 90% of the essential drugs and supplies in stock to implement IMCI

Measurement Method: Review of instruments that measure quality standards and review of the pharmacy inventories.

Major Activities	Yr 1	Yr 2	3	4	5	Personnel	Baseline/Target
Revise, adapt or strengthen the norms of obtaining essential drugs and supplies	6					IMCI manager	**Project** Baseline: 0 Target: 90.0%
Implement Quality Assurance program in respects to essential drugs and supplies	4 → 4						
Buy additional equipment and dispose of old equipment	6						
Evaluate the referral and contra-referral system in each area and implement a system	6 → 3						
Coordinate with the referral centers at the second level							
Introduce health personnel to the SUMI							

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #4: Strengthen family and community participation in the care of children under 5 years of age

Indicators:

Indicator #1 – Percent of health volunteers who score at least 90% in verification checklists of quality results in applying community IMCI

Measurement Method: Review of quality workbooks for each health volunteer and verification checklists

Major Activities	Yr 1	Yr 2	3	4	5	Personnel	Baseline/Target
Coordinate with municipality officials and MOH to establish IMCI training sessions at MOH training center	5					IMCI manager	**Project** Baseline: 0 Target: 90.0%
Develop training budget and negotiate for additional funding from other organizations	6						
Train CHWs and HVs in Community IMCI at MOH facility in both areas	7 →	→	→	→	→		
Conduct refresher courses to reinforce community IMCI strategies and quality assurance instruments	7 →	→	→	→	→	Nurse supervisors and CHWs IMCI manager	
Review HV registers of home visits	7 →	→	→			Nurse supervisors and CHWs	
Apply an incentive system for HVs	8					Nurse supervisors and CHWs	
Hold monthly meetings to present relevant cases							
Develop instruments designed to give feedback to the community	8						

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Sustainability

Objective #1: Cover a proportion of operational recurrent costs with local funds

Indicators:

Indicator #1 – Percent of recurrent costs that are recovered locally (i.e., municipality, state funds, and local sales)

Measurement Method: Annual CSRA financial reports.

Major Activities	Yr 1	Yr 2	3	4	5	Personnel	Baseline/Target
Maintain cooperative agreements with the municipality governments outlining key responsibilities	1 →	→	→	→			**Montero** Baseline: 40% Target: 65.0%
Maintain continuous dialogue with the municipality governments regarding all health activities	1 →	→	→	→			**El Alto** Baseline: 0% Target: 50%
Provide leadership training opportunities to the local authorities	8	8	8		8		

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #2: Proportion of health workers (physicians, nurses, auxiliary nurses) who consistently follow the clinical IMCI protocols

Indicators:

Indicator #1 – Percent of health workers who follow IMCI protocols

Measurement Method: Verification checklists and mid-term and final evaluations.

Major Activities	Yr 1	Yr 2	3	4	5	Personnel	Baseline/Target
Train personnel in IMCI strategy	4					IMCI manager and MOH trainer	**Project** Baseline: 0 Target: 90.0%
Supervise health personnel to ensure that IMCI is being implementing according to the established protocols	5 →	→	→	→			
Apply quality assurance controls	5 →	→	→	→			

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual month

Objective #3: Proportion of project sites have contracts signed with municipal governments and departmental health office delegating responsibility for management of local health system to CSRA

Indicators:
Indicator #1 – Percent of project sites with current contracts delegating management of local health systems to CSRA
Measurement Method: Review of signed agreements.

Major Activities	Yr 1	Yr 2	3	4	5	Personnel	Baseline/Target
Maintain corporative agreements with municipality governments outlining key responsibilities	1					IMCI manager and MOH trainer	**Project** Baseline: 0 Target: 100.0%
Maintain continuous dialogue with local authorities regarding all health activities	1 →	→	→	→	→		
Provide leadership training to local authorities							

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #3: Develop a model of health system management specifically for El Alto

Indicators:
Indicator #2 – The design, development and implementation of a health system management model for District #8 in El Alto
Measurement Method: Review of signed agreements.

Major Activities	Yr 1	Yr 2	3	4	5	Personnel	Baseline/Target
Maintain corporative agreements with municipality governments and councils outlining key responsibilities	← →	→					**Project** Baseline: 0 Target: end of project
Maintain continuous dialogue with local authorities regarding all health activities	1 →	→	→	→	→		
Coordinate meetings with municipality officials and participate in annual municipal strategic planning processes.	→	→	→	→	→		

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Objective #4: Adapt the CORE software to improve financial management

Indicators:

Indicator #1 – The CORE software is adapted and implemented in 100% of areas

Measurement Method: Review of informational systems.

Major Activities	Yr 1				Yr 2				3	4	5	Personnel	Baseline/Target
Systemize and adapt the CORE software package to the SUMI		10											**Project**
Incorporate all health services that are not included in the SUMI		12											Baseline: 0 Target: 100.0% at end of the project
Train personnel to use software					2								

Note: The arrows above signify activities that will continue on a routine basis for the life of the project and numbers represent individual months.

Capacity Building

Objective #1: Increase charitable donations received at headquarters by at least 20% over five years.												
Indicators: Indicator #1 – Percent increase of charitable grant income received at HQ *Measurement Method: Review of annual Curamericas financial records.*												
Major Activities	**Yr 1**				**Yr 2**				**3**	**4**	**5**	**Personnel**	**Baseline/Target**
Implement a corporate marketing plan	1 →										▶	Program manager	**Project** Baseline: 0 Target: 20%

Objective #1: Increase grant income for headquarters and program support by 10% over five years												
Indicators: Indicator #2 – Percent increase of income received from grants at HQ *Measurement Method: Review of annual Curamericas financial records and Program Reports.*												
Major Activities	Yr 1				**Yr 2**				**3**	**4**	**5**	**Personnel**	**Baseline/Target**
Attend grant writing seminars and workshops	→										▶	Program manager	**Project** Baseline: 0 Target: 10%
Identify foundations and donor organizations	→										▶		
Develop grant themes and proposals	→										▶		

Objective #2: Develop educational materials for field programs												
Indicators: Indicator #1 – Number of educational materials developed and pretested fpr field programs *Measurement Method: Review of annual Curamericas Program Reports.*												
Major Activities	Yr 1				**Yr 2**				**3**	**4**	**5**	**Personnel**	**Baseline/Target**
Reviewing current materials	1 →										▶	Program managers and Training manager	**Project** Baseline: 0 Target: 5
Develop and write educational materials	4 →										▶		
Pre-test and revise manuals	6 →										▶		
Publish manuals and materials		2 →									▶		

Section F: Organizational Development

Building Organizational Capacity

Organizational changes:

In July 2001, Curamericas recently changed its' name from Andean Rural Health Care (ARHC) and relocated the headquarters from western North Carolina to Raleigh, North Carolina. While recognized as Curamericas its official registered name is Andean Rural Health Care doing business as Curamericas. The new office location will provide opportunities for the organization to develop affiliations and partnerships with other international non-profit organizations and universities in the region (e.g. Research Triangle Institute, Family Health International, Duke University, University of North Carolina, and INTRAH, among others). The relocation also permits easier access to the Washington, DC area for program development and management.

Curamericas has hired a new Executive Director who brings with her experience in international development and fundraising, and an accountant with many years of non-profit experience. The Director is supported by Craig Boynton, Country Program Coordinator and Tom Davis, Senior Program Specialist. Curamericas has recently hired a Training Specialist, Mary DeCoster, who will be developing materials and curriculum to build staff capacity in various program approaches and methodologies (see Training Plan below).

Organizational development objectives:

1) Strengthen Curamericas systems to support field programs. Curamericas will twice assess its organizational capacity (see *Measuring and documenting organizational change*, below) and based on the results of the initial assessment, will establish a series of measurable organizational strengthening objectives. These objectives will address aspects of organizational functioning beyond simply the provision of technical program services. In terms of Curamericas technical program services, HQ staff will document the CBIO methodology and develop training materials on the methodology to share with other interested PVOs and NGOs. Training materials will include both manual and automated approaches to knowledge exchange, and may include web-based training strategies. Curamericas headquarter staff also will continue to pursue opportunities for professional growth and skills development through their attendance at workshops, conferences and trainings at national and international-sponsored events.

2) Increase headquarters income over the five years of the program. Over the life of the project, Curamericas will increase its support for programs from charitable donations and grant incomes. A marketing strategy has been developed for the organization, and will be implemented over the course of the program, which will improve the organization's ability to attract new donors. In addition, CSRA program staff will increase the amount of grant income for all country programs through their development of new grant proposals to a variety of funding sources.

Measuring and documenting organizational change

Curamericas conducted an initial organizational assessment at the beginning of the project using the Institutional Strengths Assessment methodology (ISA), a tool for assessing the health unit of a PVO developed collaboratively by CSTS Project, other child survival PVOs, USAID/BHR/PVC and a number of Corporative Agencies. This ISA methodology was applied at the level of the entire organization, and its results were shared with all Curamericas senior staff, the board of directors and senior managers at CSRA. The main purpose of the assessment was to evaluate the management and technical capacities of HQ staff to more effectively

implement field level health projects. Results of the study will highlight areas that need further strengthening and will assist staff to effectively plan field activities and efficient resource use. Curamericas hopes that results will reinforce strong communication between HQ staff and field level personnel and enhanced backstopping of field level activities.

The ISA methodology focuses on five conceptual areas: use of technical knowledge and skills; management practices and governance; administrative infrastructure and procedures; organizational learning; and, financial resource management. It features guided group discussions and individual scoring of the previously mentioned conceptual and capacity items. The methodology is implemented during five phases: preparation activities where an ISA coordinator introduces orientation materials; input from field programs via focus group discussions or electronic or mail-based surveys; occurrence of a self-assessment meeting using an ISA tool, which includes PVO leadership; results planning meeting to review assessment outcomes and develop recommendations and strategies to improve health unit; and, a follow-up phase which helps the organization access additional resources to meet its needs.

Curamericas' initial results show that the organization's technical knowledge and skills are generally high in both HQ and field offices. For example, the organization had an average score of 9.0/10.0 (HQ) and 8.7/10.0 (field) when questioned about programs receiving the appropriate level of support in conducting population-level surveys, such as the KPC survey. The organization's self assessment of programs receiving the appropriate level of support for operational research and sustainability was lower then other areas in the section. Overall, the organization feels that its programs and projects receive a high degree of guidance and support to continuously improve the quality of health interventions.

In the area of management practices and governance, both HQ and Field level staff require additional training in project management and additional technical assistance regarding interpretation and compliance with donor regulations. Nearly 100% of staff surveyed feel that project objectives are in line with Curamericas' overall mission. An assessment of Curamerica's administrative infrastructure and procedures revealed that regular progress reports are submitted by both HQ and field level staff. While HQ assessments of administrative procedures were high (8.0/10.0) field staff felt that procedures were not frequently reviewed and updated (4.4/10.0). Both HQ and field staff assessed that field-based project managers needed additional training and technical support in the use of computer software and hardware and a better system of internet connection that will allow managers greater access to technical health information. The ISA methodology has also identified areas of organizational learning that needs further developed such an additional opportunities to share information and experiences with other child survival projects. Finally, in the area of financial resources and human resource management, the ISA revealed that resources are transferred from HQ to the field in a timely manner and particularly in the field the organization consistently retains quality staff to support its health portfolio.

Strengthening Local Partners

As part of the project activities, CSRA will also undergo an organizational assessment of its administrative, financial and human resource processes that will address improvements of various deficiencies in the organization. At present CSRA has developed its own version of a proposal and methodology but has plans to incorporate the additional technical components addressed by the ISA methodology in its organizational development program. The CSRA

methodology will use tools such as SWOT technique, which identifies the organization's strengths, opportunities, weaknesses and advantages and in-depth interviews and surveys to analyze and redesign processes and identify concrete follow-up activities. Personnel training needs will also be identified and assessment of management abilities including delegation, decision making, prioritization and planning will be addressed. The organization development methodology will also incorporate organizational QAP standards and methods. Results of this organizational assessment will be shared with all senior CSRA staff and its board of directors.

CSRA has also recently conducted a separate human resources assessment in October 2002. Results of this assessment will be used to design an action and implementation of activities will begin in September 2003.

Curamericas anticipates that it will focus on improving the leadership and capacity skills of *CSRA* staff at all levels, and strengthen the ability of the CS Program Manager and Technical Manager to supervise and provide technical support to its programs (see Training Plan below). CSRA also will strengthen the ability of the Project Site Directors to provide leadership and advocate for appropriate CS interventions among municipal governments and the MOH. In particular, Curamericas will work with CSRA staff to improve their capacity to develop written, enforceable administrative procedures; to develop technical policies; to successfully seek potential funders and prepare competitive proposals; to improve project reporting and writing; to strengthen logistics management; to promote better interpersonal relations and communications; to improve health program abilities in neonatal and maternal health and CB-IMCI; to document program successes and challenges; to provide supportive staff supervision; and, to facilitate continuous quality improvement among staff. CSRA should, after the project, be able to effectively sustain their operations at their headquarters and in the field (An Organizational Chart of the Project can be viewed in Annex H and job descriptions of key project personnel can be found in Annex I).

Proposed Training Plan

Training Topic	Who	Responsible	When
Conducting the KPC Survey	Technical Committee/CHWs/ HVs	Curamericas	Year 1, 1st Q
Barrier Analysis	CSRA staff and field operations	Curamericas	Year 1, 4th Q
Health Facility Assessment	Technical Committee/La Paz office	Curamericas	Year 1, 3rd Q
CBIO Methodology (including home visit methodology and verbal autopsies)	All field operations staff	CSRA	Year 1, 4st Q
Cross-cultural Program	All field operations staff, Traditional Healers and MOH	CSRA/TARI	Year 1, 2nd Q
Organizational Capacity Building	Technical Committee/La Paz	CSRA/ARHC	Year 1, 3rd Q
Facility IMCI	Field operations staff	MOH/PROSIN/ CSRA	Year 1, 2nd and 3rd Q and Year 2, 4th Q
CB-IMCI	CHWs and HVs	MOH/PROSIN/ CSRA	Year 1, 4th Q and Year 2, 4th Q
Improving Quality	CSRA staff and field operations	JSI/CSRA	Year 1, 2nd Q
Maternal neonatal health care strategies: Birth deliveries (safe deliveries, danger signs) Neonatal care (resuscitation, cord care, etc.) High-risk pregnancies (recognition of high-risk pregnancies, referral systems, etc.)	Field operations staff and HVs	Curamericas/ External consultant	Year 2, 2nd Q
Monitoring and Supervision	Field operations staff	CSRA	Year 2, 3rd and 4th Q
IEC: Methods and strategies in popular education and cross-cultural relations	Health Personnel including HVs	CSRA	Year 2, 1st Q
Positive Deviance	CSRA and MOH health personnel	Save the Children/Bolivia Curamericas	Year 2, 3rd Q
TIPS (Trials of Improved Practices)	CSRA and MOH health personnel	Curamericas	Year 2, 3th Q
Birth Plans	CSRA and MOH health personnel	CARE Peru	Year 2, 2nd Q
Health System Strengthening	CSRA and MOH health personnel	CSRA	Year 2
Leadership	Municipal governments	CSRA/ Consultant	Continuous

Strengthening Local Health Systems

CSRA has a developed a strategic plan with a new vision and mission statement. As a result of this redirection, CSRA has decided to become a health NGO that jointly manages (in Bolivian terms, *co-gestion*) primary health care systems in coordination with the MOH and municipal governments in order to effectively reduce mortality rates in areas where CSRA works. For the past seven years, CSRA has been closely working with local health boards (*DLIPS)* at the local community level. Given CSRA's new strategic direction, the organization wants to work more closely with municipal authorities on strategic planning and jointly implement activities that redesign health systems that are more in tune with the population's health and social development needs.

CSRA's recently employed municipal manager, working jointly with local authorities, will adapt and develop guidelines and policies to implement a participative model of management in municipal health developed by the USAID's DDPC (*Desarrollo Democratico Participacion Ciudadana*) project. The model will be used to develop a new governing structure with active involvement of the local health boards that will represent the interests of the district. Together with CSRA and other local municipal authorities and committees, this new structure will oversee the development of a master plan for the district. This plan will address the district's health and social development needs including the construction and location of new schools and health centers.

DDPC's model proposes to help the municipality offer good quality health services that benefit the whole population and also targets those of greater need. In order to achieve this, the model assists authorities to change understanding and achieve effective organizational skills that better address community needs. The primary actors include persons who work for the municipality in the following capacities: council and executive officials such as the mayor's office, health and education sectors, vigilance committee and health boards, women's organizations and other organized groups. The local inhabitants also work alongside of authorities in planning, implementing and evaluating activities in the health and social development of its communities. All principal actors will learn more about primary health care delivery and human development and will also address financial considerations[17].

[17] Desarrollo democratico participacion. *Modelo de Gestion Municipal Participativa*. La Paz, Bolivia.

Section G: Sustainability Plan

Definition of Sustainability: Curamericas/CSRA defines sustainability as the continuous, indefinite provision of benefits (quality health services) to specified community or set of communities.

Sustainability Assumptions: This sustainability strategy is based on two fundamental assumptions. First, the Bolivian government will continue to have a strong interest in decentralizing health care to the municipal level. International agencies such as the World Bank and the International Monetary Fund, which hold enormous influence over national policy, have promoted decentralization within Bolivia and it is assumed will continue to do so in the future.

The second assumption is that there will be increasing interest in outsourcing as a strategy for governments at different levels to provide quality services. CSRA will provide management services to different levels of government in the health sector, establish contractual arrangements that carefully state obligations on the parts of all parties concerned, and develop shared mechanisms that assure compliance.

Strategy for achieving sustainability

In order to have a sustainable health system the following elements are required: 1) an adequate flow of resources; 2) a product that is necessary or demanded; 3) the technical knowledge or "know how" to provide the product(s) competitively; 4) an organizational structure that guarantees accountability, creates and sustains clear goals and objectives, reinforces core values and provides a stable and desirable labor environment; 5) leadership capable of visualizing the future and moving the organization toward change; and, 6) ownership among all involved organizations.

Since 1994, as a result of the "Law of Popular Participation," the Bolivian central government has devolved funds to the municipal governments for investment in productive infrastructure, education, health, culture and sports. So far, the national government has determined that 6.4% of these devolved funds be set-aside for the Basic Health Insurance. According to this plan, public sector providers are reimbursed for the costs of medicines and supplies for a list of about 70 activities, most of which are related to maternal and child health and illness.

CSRA has been successful in previous projects in mobilizing municipal resources beyond those set aside for the functioning of the SUMI program. CSRA project site directors will develop, negotiate and follow up on written agreements with each municipal government regarding the details of the mutual relationship, and will work closely with the municipal governments so that they will better understand the differences between responsible human development and oversized infrastructure development. CSRA will coordinate with the municipal governments annually to develop the health system budget according to priority needs, including setting aside additional funds for PHC and investing those funds to cover recurring operating expenses instead of in unnecessary infrastructure and equipment. Each project site director and administrator will work with the governments to secure the timely disbursement of municipal funds.

CSRA will enter into contractual arrangements with the MOH of the Departments of La Paz and Santa Cruz. The MOH financial contributions to the project will be from salaried positions and

are a substantial portion of the in-country source of income for the health system. CSRA will be managing all MOH personnel in each project site, and the salaries of MOH staff will be accounted for as matching funds for the CS program. Project management personnel will be responsible for evaluating the MOH staff and recruiting new employees. Other in-country income for the health system will come from the sale of services, and the medicines and supplies provided as part of the SUMI program.

The main interests and demands of local authorities and most community members are for ongoing, accessible (culturally and economically), inexpensive and increasingly specialized curative care. Most beneficiaries are accustomed to western medical and health services, if available, being provided free of charge, or largely subsidized by government, non-profit organizations or churches. In CSRA's experience, it is key to the sustainability of CS services that they be integrated with the other services that the local health system provides. Therefore, CHWs, HVs and professional staff will not only carry out CS interventions, but they will be responsible for providing other parallel preventive, educational and basic curative services in their respective assigned communities.

Leadership is an important function that needs to be fulfilled if a productive effort is going to survive into the future. Health systems need people who think about the future and can work with local leaders from different sectors to plan and prepare for times to come. These leaders need to have some understanding of the past health systems as well the ability to think about the future. CSRA's project site directors will work with the Municipal Health Councils (MCH) and strategically look at the health needs of their jurisdictions and will assist them in lobbying with municipal and health sector authorities for the required resources and solutions.

CSRA has recruited and trained project directors for each site. These individuals are public health professionals, with some experience in marginal urban health activities and an understanding of MOH policies and priorities. The training covered the CBIO methodology, co-administration of health care systems and other CSRA strategies, CSRA history, values and future directions. Site directors new to the organization will spend three months in one of CSRA's older project sites for in-service training.

A sense of ownership is one of the most important elements for a local health system to be sustained. To promote a sense of shared ownership of the local health system, CSRA will actively promote the development and institutionalization of the MHCs. By law, the MHCs are to meet regularly with representation from the mayor's office, the Municipal Council, the Municipal Citizens Oversight Committee, the MOH District Director, and locally involved NGOs. Although significant time is required to promote, organize and motivate these Boards, project site directors will be actively working to make them operational.

CSRA developed a training manual for health system management staff and municipal authorities to assist in orienting them in their roles and responsibilities in the current decentralized environment. CSRA is also working with the USAID DDPC project to refine and validate additional materials for training municipal governments in managing local health systems. These materials will be used to work with the MHCs in each project site to better understand human development, public health in general, public health problems in their

jurisdiction in particular, national health policies and the functioning of the national health system, the Basic Insurance Plan, and other pertinent information.

Finally, Curamericas will work with CSRA, particularly in the Montero project clinics, to create self-financing "profit centers" of high quality PHC services. Our interest here, as in other Curamericas PHC projects in other countries, is to create the skills and interests of NGO headquarters and local senior staff to focus on local demand and capacity to pay for health services, and to create a service provision, marketing and fee structure that maximizes their income. If successful, such a clinic serves as: a cross funding mechanism within the NGO to cover selected outreach and preventive health activities not amenable to cost recovery; a resource of technology and service innovation (because of increased funding); and, a center for the management of more complex cases referred by field staff. Eventually, Curamericas recognizes that local health services must be sustainable in-country, and this is another means of achieving that long-term objective.

ANNEX A: MAP OF PROJECT SITE

ANNEX B: RESPONSES TO PROPOSAL COMMENTS AND FINAL EVALUATION

DCHA/PVC Child Survival Application Comments

1. "*No data are presented on: breastfeeding and complementary practices; micronutrient status; and immunization coverage."*

The project has incorporated Rapid CATCH indicators in priority child health intervention areas (Section B: CSHGP Data Form, Rapid CATCH indicators) that include data on breastfeeding practices, care seeking practices of pregnant women and children and complete immunization coverage rates for all WHO recommended vaccines. The baseline assessment incorporates Rapid CATCH indicators and includes information about knowledge of danger signs and care seeking behavior (see Section E: Baseline Results).

2. *"Project objectives could include improving quality of care and homecare and care seeking practices."*

Quality assurance methods, which address health personnel performance and quality of home care have been incorporated by the project and is considered a priority program strategy. Quality of care improvements will also be achieved via the project's intercultural program that will address better care seeking practices.

3. "*Not clear how some elements of community level activities will be implemented including: how HVs are selected and organized; how supervision will be conducted; and, roles and responsibilities and training content."*

During DIP development, both program sites designed a detailed training plan and schedule for HVs. Recruitment of volunteers will be conducted during coordination and informational sessions with community members in order to receive their input in the selection of persons that are known and valued.

The project has identified several specific objectives for the volunteer training program. It seeks to educate and promote a more humanized approach of health care delivery that offers intercultural aspects and implements Information, Education and Communication (IEC) techniques in home visits and during organized community events. Volunteers will be trained to recognize and differentiate between various dangers signs in women and newborn infants and promote key health messages in the IMCI strategy. The volunteers will also have an opportunity to learn and implement the expanded CBIO methodology and conduct census, community surveillance activities such as the collection of vital events, risk cases, births and deaths through regular home and follow-up visits.

Specific training subjects and themes addressed in the intercultural training sessions include human rights, concepts and practices of both cultures, improving health services and traditional medicine. The IEC training will focus on how best to use educational materials to convey key messages and will also include Linkages materials and will apply the 'ORPA' process with mothers to create awareness and take action. Other training topics will address improving key messages of the IMCI strategy and sessions on the CBIO that focus on how to fill out forms and basic registers and specific instructions on follow-up visits and referrals. Training sessions will

be held every 3 months based on a previously agreed upon schedule drafted by the HVs and health personnel. Sessions will be active and participatory in order to engage volunteers and increase retention of materials.

A supervisor will accompany HVs at least twice a year to obverse and offer feedback. Every quarter volunteer activities and performance will be evaluated by other health personnel in conjunction with community members. Verification checklists and revisions of basic registers for quality control will be employed to ensure that vital events are recorded accurately, high-risk cases are detected and follow-up activities are performed on a timely basis.

4. "No activities proposed for improving and monitoring the practices of traditional healers or drug vendors who are important providers of care in these communities."

CSRA and Curamericas will be incorporating an intercultural program that will complement the IMCI strategy to bridge the gap between traditional practitioners and health personnel. These results point to the evidence of cultural barriers, which affect the quality and access to services. The project also felt that it was important to address the practices of traditional practitioners in order to have positive outcomes in areas where they are more prevalent. The program will modify existing clinical protocols such as the IMCI strategy to emphasis changes in intercultural practices that consider the values and beliefs of the client. Through various training sessions and workshops, health personnel and local authorities will incorporate basic human right principles and also better understand intercultural practices particularly in the project's key intervention areas.

During implementation of the intercultural model, the relationship between health personnel and traditional practitioners will also be strengthened. Specific activities conducted in the project's first year include: ensuring the adequacy of a cultural appropriate environment and clinical protocols, inter-cultural training workshops for health personnel, local authorities, and other organized groups, and workshops among health personnel and traditional practitioners in order to share experiences and practices. Activities will first be implemented in El Alto; Montero will begin activities in the project's third year.

5. "Not clear how quality of care at health facilities will be defined, supported or measured."

Quality assurance standards that focus on improving health personnel case management skills will facilitate health service quality improvements. Patient satisfaction surveys at the household and health center level will be utilized to assess quality of health services. Health worker and volunteer performance will be strengthened through a process of accompaniment during home and health visits by both CSRA and MOH personnel. Monthly CAI meetings will also provide an effective manner to mobilize and motivate HVs and CHWs to offer quality health services to respective communities.

6. "The IMCI nutrition food-box could be used for nutrition counseling and HVs could be given training in nutritional counseling for persistent diarrhea.

The MOH has adapted WHO's IMCI strategy to fit their own needs in the area of nutrition and micronutrients. The adaptation phase has already occurred and protocols are in place that

addresses assessment, classification, and rehabilitate treatment and preventive measures such as growth monitoring and nutritional counseling. In order to conduct counseling, the MOH has developed a nutrition food-box, which will be used by HVs and other health personnel during home and health center visits and other community group meetings.

7. "The community-based census system could be described in more detail."

Project HVs supervised by CHWs maintain records of their community-based activities and home visits to capture household level information. This information includes the name of each family member, sex and ages of members, reported illnesses, prescribed treatment, whether any referral has taken place, current family planning methods, a description of the specific counseling session, births and deaths in the household and information regarding migration. Health personnel also collect information regarding vital events and results of verbal autopsies, which provide important information on the number and causes of deaths of children and women of reproductive age. Additional household information such as the existence of a drinking water and sanitation system is also collected. During home and health center visits, health workers also complete child and maternal health cards to record growth monitoring, vaccination status and prenatal controls. Duplicate cards and additional forms are also present in the health centers, which capture case histories for the family and reproductive histories for women and pregnant women.

At the conclusion of every month, community level data from basic registers and health center forms are consolidated and a SNIS summary form is submitted to local MOH officials, other local partners (mayor's office, vigilance committee, neighborhood boards and health boards) CSRA, Curamericas and USAID. Summary data is also shared with individual communities and presented during CAI meetings. At the community level, CHWs will share data with their own respective households as part of the new expanded CBIO approach.

Response to Final Evaluation Recommendations

1. "Little progress was made in the following indicators: maternal knowledge of danger signs of pneumonia and diarrhea; Vitamin A supplementation to women and children; iron supplements to women; prenatal care and birth attendance by trained persons; and, TT coverage.

With the exception of iron supplementation, all indicators mentioned above have been included in the project's key indicator list (see Work Plan). These interventions will be addressed and progress will be monitored on an annual basis. Key program strategies such as IMCI, CBC and quality assurance will facilitate improvements.

2. "Some strategies detailed in the DIP were not included, including the Hearth Model, TBA strategies, Factor Analysis and use of the Pneumonia Toolbox.

While some strategies were not implemented, additional methods are included in the project's current DIP. These include: Birth Plans, TIPS, ProPan, and Positive Deviance. Factor Analysis will be used to improve CBC implementation.

3. "Systematic support to HVs and provision basic health education materials are needed."

The project's supervisory strategy will provide support and constructive feedback to HVs. A supervisor will accompany HVs at least twice a year to obverse and offer feedback. Every quarter volunteer activities and performance will be evaluated by other health personnel in conjunction with community members. Verification checklists and revisions of basic registers for quality control will be employed to ensure that vital events are recorded accurately, high-risk cases are detected and follow-up activities are performed on a timely basis. Performance monitoring will also be conducted on a team basis all members contribute to improvements.

4. A key are of difficulty was the "shared management" model implemented between CSRA and the MOH.

CSRA will implement a participative model of management in municipal health developed by the USAID's DDPC (*Desarrollo Democratico Participacion Ciudadana*), which proposes to help the municipality offer good quality health services that benefit the whole population and also targets those of greater need. In order to achieve this, the model assists authorities to change understanding and achieve effective organizational skills that better address community needs. The primary actors include persons who work for the municipality in the following capacities: council and executive officials such as the mayor's office, health and education sectors, vigilance committee and health boards, women's organizations and other organized groups. The local inhabitants also work along side authorities in planning, implementing and evaluating activities in the health and social development of its communities. All principal actors will learn more about primary health care delivery and human development and will also address financial considerations[18].

[18] Desarrollo democratico participacion. *Modelo de Gestion Municipal Participativa*. La Paz, Bolivia.

ANNEX C: DIP PREPARATION METHODOLOGY, SCHEDULES AND WORKSHOP PARTICIPANTS

Consultant's Scope of Work

Terms and scope of services:

Purpose: The purpose of this consultancy is to work with Curamericas' partner, Consejo de Salud Rural Andino, to prepare and the Detailed Implementation Plan (DIP) for Curamericas' Child Survival Project (2002-2007), *Providing Child Survival Services to Rural and Peri-Urban Populations in Bolivia.* This document will serve as the detailed guide for the above child survival and health project.

Product: The product of this consultancy is a written document that follows the format of USAID's Detailed Implementation Plan guidelines and will include a diskette of this document. This document will be in English.

Objectives of the Detailed Implementation Plan: The purpose of the DIP is provide: results of baseline studies; changes in program interventions/strategies and/or a revised budget based on those studies; the overall approach and a detailed plan of action for the first two years of the project. The preparation of the DIP provides the opportunity to create a shared vision among partners, plan and or revise the major interventions, spell out roles and responsibilities, and refine project activities with established goals, objectives and indicators.

Specific Activities:

The consultant will be responsible for the following activities:

- Review relevant project documents, DIP guidelines and baseline survey results.
- Lead a planning and methods workshop that refines the work plan and schedule for DIP development;
- Review of baseline qualitative and quantitative data in a Data Analysis Workshop;
- Review of national and district level data from MOH, USAID and other available sources in Data Analysis workshop;
- Lead participatory workshops at each project site and conduct key informant interviews;
- Work with key CSRA staff to develop project goals, objectives and indicators;
- Develop interventions, activities and a detailed timeline of the first two years to carry out the proposed activities;
- Ensure that the proposed interventions are in accordance with the latest State of the Art (SOA) technical materials and guidelines as established by WHO, USAID, and the Bolivian MOH;
- Submit a draft document that consolidates results to Curamericas and CSRA for review and revisions; and,
- Submit final written DIP including all relevant supporting attachments.

Tentative Schedule and Work plan

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Mar 2	**Mar 3** Document review Questionnaire development	**Mar 4** Document review Questionnaire development	**Mar 5** Travel to Montero Lead planning and methods workshop with staff and local partners **MONTERO**	**Mar 6** Participatory workshop and conduct interviews with key staff and partners **MONTERO**	**Mar 7** Data Analysis Workshop Summarize data results **MONTERO**	**Mar 8** Prepare for La Paz trip Revise questionnaires
Mar 9 Travel to La Paz	**Mar 10** **Lead planning and methods workshop with staff and local partners** Presentation of data summary Define project objectives, goals and indicators **LA PAZ**	**Mar 11** Participatory workshop and conduct interviews with key staff and partners **EL ALTO**	**Mar 12** Data Analysis Workshop Refine indicators (including sources and definitions) **EL ALTO**	**Mar 13** Develop and draft interventions, strategies, associated activities, and timeline **LA PAZ**	**Mar 14** Refine interventions and associated activities and timeline Develop Workplan templates **LA PAZ**	**Mar 15** Develop report outline including list of annexes **LA PAZ**

Mar 16	**Mar 17** Draft monitoring and evaluation plan and schedule. Develop Performance Monitoring Plan **LA PAZ**	**Mar 18** Finalize PMP Identify roles and responsibilities of partners Prepare organizational chart **LA PAZ**	**Mar 19** Annex development Budget revisions **LA PAZ**	**Mar 20** Finalize report outline and annexes **Depart for Santa Cruz**	**Mar 21**	**Mar 22**
Mar 23	**Mar 24** Travel to the US	**Mar 25**	**Mar 26** Report Writing	**Mar 27** Report Writing	**Mar 28** Report Writing	**Mar 29** Report Writing
Mar 30	**Mar 31** Report Writing	**April 1** Report Writing	**April 2** Report Writing	**April 3** Report Writing	**April 4** Report Writing	**April 5** Report Writing
April 6	**April 7**	**April 8**	**April 9**	**April 10**	**April 11**	**April 12**
April 13	**April 14** Draft report sent to Curamericas for review	**April 15**	**April 16**	**April 17**	**April 18** Comments sent to consultant	**April 19** Report revisions
April 20	**April 21** Report Revisions	**April 22** Final Report submitted to Curamericas				

PARTICIPANTS LIST
BASELINE ANALYSIS WORKSHOP
MONTERO - MARCH 7, 2003

TECHNICAL TEAM MEMBERS AND KEY ADMINISTRATIVE PERSONNEL

Name	Job Title
Dr. Dardo Chavez	EXECUTIVE DIRECTOR MONTERO
Sra. Mirtha Sanjinez	REGIONAL ADMINISTRATOR MONTERO
Lic. Mitma de Chavez	NURSING MANAGER VILLA COCHABAMBA
Lic. Rosa Muñoz	NURSE SUPERVISOR VILLA COCHABAMBA
Sonia Llanto	AUXILARY NURSE VILLA COCHABAMBA
Maria Esther Claros	STATISTACIAN VILLA COCHABAMBA
Mario Darlin Escobar	HIS MANAGER VILLA COCHABAMBA
Eduardo Montecinos	PHYSICIAN CRUZ ROJA
Silvia Ajhuacho	NURSE SUPERVISOR CRUZ ROJA
Marleny Suarez	AUXILARY NURSE CRUZ ROJA
Dalcy Paz	ADMINISTRATOR CRUZ ROJA
Marina Tenorio	NURSE SUPERVISOR CLEM
Margoth Uriona	AUXILARY NURSE CLEM
Magdalena Bravo	ADMINISTRATOR CLEM

LA PAZ OFFICE PERSONNEL

Name	Job Title
Hernán Castro	PROJECT DIRECTOR
Ramiro Llanque	DIRECTOR OF IMCI

CURAMERICAS PERSONNEL

Name	Job Title
Craig Boynton	Regional Program Manager
Sujata Ram	DIP Consultant

PARTICIPANTS LIST

PLANNING WORKSHOP WITH LOCAL AUTHORITIES AND STAKEHOLDERS
MONTERO - MARCH 10, 2003

No	NAME	TITLE
1	Pilar Villaroel	Supervisor of Health Services – MOH, Montero
2	Máxima Murillo	Vice President of the Community Volunteers –Villa Cochabamba
3	Marlene Ortiz	Vice President of the Community Volunteers –Cruz Roja
4	Sara Abariega	Community volunteer CLEM
5	Antonio Acha	Director of Health Services Montero
6	Craig Boynton	Program Manager Curamericas
7	Sujata Ram	Consultant Curamericas
8	Ramiro Llanque	Technical Manager CSRA
9	Mario Chirico	Director of the Vigilance Committee
10	Isabel Justiniano	Member of the Vigilance Committee
11	Silvia Ajuacho	Coordinator Cruz Roja CSRA
12	Maria E. Claros	Auxilary Nurse Villa Cbba CSRA
13	Mirtha Sanjinez	Administrator CSRA Montero
14	Rosa Muñoz	Coordinator Villa Cbba. CSRA
15	Hernán Castro	Technical Manager CSRA
16	Enrique Echegaray	DILOS Montero

PARTICIPANTS LIST
BASELINE ANALYSIS WORKSHOP
EL ALTO - MARCH 14, 2003

No.	NAME	TITLE
1	Franz Trujillo	DIRECTOR OF THE PROJECT IN EL ALTO (CSRA)
2	William Valencia	TECHNICAL MANAGER EL ALTO (CSRA)
3	Maria Pérez	NURSE SUPERVISOR EL ALTO (CSRA)
4	Rocio	DENTIST EL ALTO (CSRA)
5	Luciano Tintaya	FIELD COORDINATOR EL ALTO (CSRA)
6	Prudencio Ramos	ADMISTRATOR/ACCOUNTANT EL ALTO (CSRA)
7	Sixto Cancari	DRIVER EL ALTO (CSRA)
8	Sujata Ram	CONSULTANT CURAMERICAS CS 18 (CSRA)
9	Ramiro Llanque	IMCI DIRECTOR (CSRA)
10	Hernán Castro	PROJECT DIRECTOR CS 18 (CSRA)

PARTICIPANTS LIST

SENIOR MANAGEMENT MEETING

CENTRAL OFFICE OF CONSEJO DE SALUD RURAL ANDINO
LA PAZ MARCH 20, 2003

No.	**NAME**	**TITLE**
1	Gloria Laime	DIRECTOR OF FINANCES
2	Juan Guillermo Puña	ADMINSTRATIVE DIRECTOR
3	Javier Baldomar	HUMAN RESOURCE DIRECTOR
4	Maria Elena Ferrel	TECHNICAL DIRECTOR
5	Nathan Robison	NATIONAL DIRECTOR
6	Franz Trujillo	PROJECT DIRECTOR IN EL ALTO (CSRA)
7	Sujata Ram	CONSULTANT CURAMERICAS
8	Mirtha Aguilar	CBIO DIRECTOR
9	Hernán Castro	PROJECT DIRECTOR

ANNEX D: BUDGET FORMS 424 AND 424A AND BUDGET NARRATIVE

Standard Form 424 OMB Approval No. 0348-0043 **RFA 938-2002-A-0500-18**

APPLICATION FOR FEDERAL ASSISTANCE

		2. DATE SUBMITTED April 29, 2003	Applicant Identifier NA
1. TYPE OF SUBMISSION:		3. DATE RECEIVED BY STATE	State Application Identifier
Application	Reapplication NA	NA	NA
____ Construction	____ Construction	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier
__X__ Non-Construction	___ Non-Construction		NA

5. APPLICATION INFORMATION

Legal Name: Curamericas	**Organizational Unit**
Address (give only county, state, and zip code): 224 E. Martin, Raleigh, NC 27601	Name and telephone number of person to be contacted on matters involving this application (give area code) Craig Boyton – 919-821-8000

6. EMPLOYER IDENTIFICATION NUMBER (EIN): 56-1400098	7. TYPE OF APPLICATION: (enter appropriate letter in box)..... M A. State H. Independent School Dist B. County I. State Controlled Institution of Higher Learning C. Municipal J. Indian Tribe D. Township K. Individual E. Interstate L. Profit Organization F. Inter-municipal M. Other (specify) G. Special Dist.
8. TYPE OF APPLICATION __X__ New ____ Continuation ____ Revision If Revision, enter appropriate letter(s) in box(es)..... A. Increase Award D. Decrease Duration B. Decrease Award E. Other (specify): C. Increase Duration	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: NA TITLE:	9. NAME OF FEDERAL AGENCY USAID/BHR/PVC 11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Providing Child Survival Services to Rural and Peri-Urban Populations in Bolivia.
12. AREAS AFFECTED (Cities, Counties, States, etc.): NA	

13. PROPOSED PROJECT		14. CONGRESSIONAL DISTRICTS OF:	
START DATE: October 1, 2002	END DATE: September 30, 2007	a. Applicant NA	b. Project NA

15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. Federal	$1,300,000	
b. Applicant	$1,300,000	a. YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS REVIEW ON:
c. State	$ NA	
d. Local	$ NA	DATE
e. Other	$	B. NO. __X__ PROGRAM IS NOT COVERED BY E.O. 12372 __X__ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW
f. Program Income	$	
g. TOTAL	$2,600,000	

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT? ____ Yes If "Yes", attach an explanation __X__ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Type Name of Authorized Representative Jennifer Babula	b. Title Executive Director	c. Telephone Number (919)821-8000
d. Signature of Authorized Representative		e. Date Signed

Standard Form 424 (REV 4-92); Prescribed By OMB Circular A-102

Standard Form 03 424A Budget Information - Non-Construction Programs RFA 938-2002-A-0500-18

SECTION A - BUDGET SUMMARY						
Grant Program Function Or Activity {a}	Catalog of Federal Domestic Assistance Number {b}	Estimated Unobligated Funds		New or Revised Budget		
		Federal {c}	Non-Federal {d}	Federal {e}	Non-Federal {f}	Total {g}
1. Headquarters	$ NA	$ NA	$ NA	$ 425,512	$ 400,213	$ 825,725
2. Field	NA	NA	NA	874,488	899,787	1,774,275
3. NA	NA	NA	NA	NA	NA	NA
4. NA	NA	NA	NA	NA	NA	NA
5.TOTALS	$ NA	$ NA	$ NA	$ 1,300,000	$ 1,300,000	$ 2,600,000

SECTION B - BUDGET CATEGORIES					
6. Object Class Categories	USAID PROGRAM		RECIPIENT FUNDS		Total {5}
	(1) Federal	(2) Non-Federal	{3}	{4}	
a. Personnel (1)	$ 505,618	$ 351,031	$ NA	$ NA	$ 856,649
b. Fringe Benefits (1)	149,397	105,307	NA	NA	254,704
c. Travel (2)	58,450	13,100	NA	NA	71,550
d. Equipment (3)		140,000	NA	NA	140,000
e. Supplies (4)	7,540	19,500	NA	NA	27,040
f. Contractual (5)	115,791	4,506	NA	NA	120,297
g. Construction		281,450	NA	NA	281,450
h. Other (6)	194,951	385,106	NA	NA	580,057
i. Total Direct Charges (sum of 6a-6h)	1,031,746	1,300,000	NA	NA	2,331,746
j. Indirect Charges (4)	268,254		NA	NA	268,254
k. TOTALS (sum of 6i and 6j)	$ 1,300,00	$ 1,300,000	$	$	2,600,000
7. Program Income	$	$	$	$	$

STANDARD FORM 424A (cont'd)

SECTION C - NON-FEDERAL RESOURCES				
(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. Headquarters	$ 400,213	$ NA	$	$ 400,213
9. Field	899,787	NA		899,787
10. NA	NA	NA	NA	
11. NA	NA	NA	NA	
12. TOTAL (sum of lines 8-11)	$ 1,300,000	$ NA	$	$ 1,300,000

SECTION D - FORECASTED CASH NEEDS					
13. Federal	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th quarter
	$ 322,547	$ 80637	$ 80,637	$ 80,637	$ 80,636
14. Non-Federal	392,165	98,042	98,041	98,041	98,041
15. TOTAL (sum of lines 13 and 14)	714,712	178,679	178,678	178,678	178,677

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT				
(a) Grant Program	Future Funding Periods			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. Headquarters	$ 78,611	$ 77,267	$ 74,517	$ 90,586
17. Field	171,862	167,080	148,474	169,057
18. NA	NA	NA	NA	NA
19. NA	NA	NA	NA	NA
20. TOTAL (sum of lines 16-19)	$ 250,473	$ 244,346	$ 222,991	$ 259,643

SECTION F - OTHER BUDGET INFORMATION	
21. Direct Charges:	22. Indirect Charges: Provisional rate of 24%
23. Remarks:	

Budget Narrative

Curamericas requests funding from USAID of $1,300,000 for five years, and will contribute a PVO NGO match of at least an additional $1,300,000 to this project.

USAID Portion of the Proposed CS Project

1. **Personnel and fringe** - Personnel and fringe estimates are included for Bolivian field and Curamericas HQ staff. The fringe rate for CSRA is 31%, and the fringe rate for Curamericas HQ is 22%. For CSRA and Curamericas staff, 3% yearly increases are included. Curamericas Country Program Coordinator will dedicate 30% of his time to backstopping the project. Additional HQ staff includes Curamericas Director of International Programs and the Country Program Specialist. Each will be dedicating 5% of their time to CS activities in Bolivia, and will be supported by matching funds. CSRA staff includes management and field workers who will contribute to the implementation of this project.

   In the process of developing the DIP, and more carefully identifying the technical needs of the project, the number of salaried positions supported by the AID portion of the grant increased. The amount of the grant used for salary support and fringe benefits remained unchanged.

2. **Travel** – Funds are requested for field travel to and from Bolivia, Peru and within the US. Curamericas staff will meet with USAID CSP staff and attend two professional meetings in Washington DC (CORE Group conference, Global Health Conference) each year at an estimated cost of $860/trip ($200 roundtrip airfare and estimated daily expenses of $165/day for four days each trip). The Country Program Coordinator also will travel three times a year to Bolivia to provide technical assistance and onsite visits at an estimated cost of $2,270 per trip. (The estimated cost for a roundtrip ticket to Bolivia is $1,500, and the daily expenses are estimated at $55/day.)

   CSRA staff travel includes trips in Years 1, 2**,** 3, 4 and 5 for a senior CSRA manager to visit Curamericas HQ for meetings and to attend the APHA annual conference if feasible within travel budget. The estimated cost for travel to Curamericas is $1,450 including $ 1,000 for airfare and $90/day for expenses in Raleigh, NC. Total USAID funds to cover the costs of travel to Curamericas HQ and APHA annual conference is $10,677. The CSRA CS Program Manager also will travel to visit the CARE CS program in Peru for cross-training in CARE's successful implementation of maternal and neonatal health care. The trip to Peru is estimated at $ 800 and USAID funds are estimated to cover $ 600 for a roundtrip ticket.

   CSRA is budgeting funds for travel between La Paz and Montero, for project related assistance and monitoring. $ 1,400 per year will be spent on airfare and $ 945 for food and lodging.

3. **Equipment** – No equipment purchases are planned with AID funds.

4. **Supplies** – A supplies budget is requested for the field projects. This category of expenses covers a modest range of items required to support field operations, and include: office supplies such as paper, pens, pencils, staples, paper clips, tape, calendars, rulers, etc. It also will include items such as computer support materials like printer ink cartridges, photocopier toner, photocopy paper, etc. The costs for the office supplies are estimated at $125 a month for the life of the project. No supplies are requested to be funded by USAID at Curamericas HQ.

5. **Contractual Services** – In the CSRA La Paz offices, $11,000 is budgeted for the quantitative and qualitative survey related for conducting baseline assessments in the first year of the project, including training workshops for staff and HVs. In years three and five, Curamericas will hire external consultants to conduct a mid-term and final evaluation of CS-18. CSRA is budgeting for quantitative and qualitative survey and logistical support costs of the midterm and final evaluations. Curamericas and CSRA will contract with public health consultants to provide technical assistance to the project on, marketing, human resource development, inter-culturally**,** and behavior change communication.

   Curamericas will contract with an external evaluator to conduct the PVO assessment during year 1 and year 5 of the project. CSRA will hire consultants for the improvement of administrative, financial and human resource management systems. CSRA is budgeting $ 20,000 for external auditing of project at the rate of $ 4,000 a year during the five years. $ 20,000 originally budgeted for implementing the PROPAN nutritional strategy, was shifted to other items after it was determined that PAHO recently concluded a PROPAN study in the project area in El Alto, which will be used to orient project nutritional interventions.

   The total of the field portion of the Contractual line item was reduced from $ 126,563 to $97,500 in order improve CSRA's ability to meet the project budget requirements for training.

6. **Other** – Other direct costs include program-related telephone charges for calls to Bolivia, CORE Group, other PVOs, and USAID in Washington D.C. from Curamericas HQ.

   Other direct costs in Bolivia include charges for communications, photocopying, vehicle maintenance, utilities, and equipment maintenance. $ 5,000 has been included in the reformulated budget for the purchase, adaptation and reproduction of maternal and child health communications materials.

   Training is also included in the other direct costs category. Training expenses, for a total of $ 128,913, vary based on the duration of the training, the number of participants, and if the training is to be conducted at a project site or in a central location such as La Paz. CSRA is including specific training follow-up costs, such as travel expenses and training supplies in the training budget. Aside from the originally budgeted Barrier Analysis, Project Kickoff, Organizational Introduction, IMCI, Census Based Approach, Birth Planning, and Trials for Improved Practices workshops, supervisor and administrative training, the budget in including funds for the Project Pre-implementation, Quality Assurance, Health Information System (HIS), Organizational and Administrative Improvement, Project Monitoring and

Evaluation, Health Facility Assessment, Supervision, Inter-cultural, and Behavior Change Communication training. Funds are also included in the budget for training sessions with local and municipal authorities.

7. **Total Direct Expenses** – Total AID funded direct expenses are anticipated to be $1,031,746 over the five-year agreement period. Curamericas HQ expenses are 15% of this amount.

8. **Indirect Expenses** – The AID approved provisional indirect rate for Curamericas currently is 24%. Total indirect expenses for the CS-18 program are $268,254.

9. **AID/BHR/PVC Total** – The total estimated AID funded budget equals $1,300,000 for the five-year period.

PVO Match of the Proposed Project

1. **Personnel and fringe** – CSRA will match AID requested support for personnel and fringe with $ 456,338 provided primarily through: municipal and MOH income in-country; and, through charitable contributions and foundation grant support in the US. The CSRA fringe rate is 31% and the Curamericas fringe rate is 22%.

As a result of the geographical changes away from the rural municipalities of Puerto Acosta and Alto Beni, where very significant levels of MOH staff would have been in place for implementation of the project, to urban areas where MOH presence at the beginning of the project is minimal, CSRA has had to substantially reduce its counterpart commitment in salaries from $ 559,493 to $ 408,731.

2. **Travel** – Curamericas will provide matching funds to the USAID funds for HQ travel to Washington DC to attend health conferences and workshops, and to attend the American Public Health Association (APHA) annual conference (held in different cities).

   Additional matching funds will cover travel costs for CSRA staff to come to Curamericas' HQ annually for meetings and to attend the APHA annual conferences in the United States. Match also will cover the costs of CSRA program staff travel to visit the CARE CS program in Peru.

3. **Equipment** – Curamericas will assist CSRA to purchase three Toyota Land Cruisers to support CS activities during the life of the project. The municipal governments**,** and CSRA's Partners (CLEM and Red Cross – Montero) will be contributing to the match through their construction and equipping of new health facilities and remodeling older health facilities. The increases in match in the equipment and construction line items are the result of the reduction in the match in the personnel line item, as explained above.

4. **Supplies** – An estimated $12,000 of match will be provided through the local purchase of CS supplies for the field. These items include child growth charts, vaccines, syringes, cotton, alcohol, ORS packets, pharmaceuticals, etc. which are reimbursed by the Bolivian Basic

Health Insurance law. Additional office supplies for the field will be purchased by non-USAID funds.

5. **Contractual Services** – Curamericas will provide matching funds for external consultants to provide technical assistance in the nutritional methodology PROPAN, to conduct an external evaluation of the project, and to conduct a final PVO assessment in Year 5 of the project.

6. **Other Direct Costs** – Other direct costs that will be matched during this project include Curamericas HQ office expenses for photocopying CS materials and sending CS correspondence to CSRA HQ via an international courier service. Curamericas sponsored Work-Amigo Teams each year will provide financial and labor assistance to project sites for each of the five project years. These teams are composed of about 12 to 15 US volunteers per team who assist in the construction of health project or development related structures, and who pay their own expenses. The teams usually cost a total of about $30,000 per team.

7. **Total Direct Expenses** – Total direct project expenses paid by non-government sources that will be reported to AID will be $1,300,000 over five years. We consider this be a conservative estimate of actual costs to be incurred.

8. **Indirect Expenses** – No match will be reported in this category.

9. **PVO Match Total** – The total amount to be matched for this project by ARHC/CSRA is estimated to be $1,300,000 over five years.

PROJECT GRAND TOTAL - The combined proposed budget to be supported by both USAID and the PVO and its partners is estimated to be $2,600,000.

ANNEX E: FORMAL AGREEMENTS WITH LOCAL PARTNERS

AGREEMENT OF INTER-INSTITUTIONAL COORDINATION BETWEEN FREEDOM FROM HUNGER AND CONSEJO DE SALUD RURAL ANDINO

The following Inter-Institutional Agreement has been signed between Freedom from Hunger /CRECER, represented by its General Manager, Mrs. Evelyn Grandii, from now on called FFH/CRECER and the Consejo de Salud Rural Andino (CSRA), represented by its National Director Lic. Nathan Robison, from now on called CSRA subject to the following clauses and stipulations.

FFH/CRECER, as a non-governmental non-profit organization, with ministerial resolution No. 143/91 working in the rural areas of the departments La Paz, Cochabamba, Oruro and Potosi, whose mission is to improve the quality of life of rural families with little means of support.

CSRA, as a non-governmental non-profit organization with legal status recognized by the Supreme Resolution No. 211215, offering services in health and communitarian development in the provinces Omasuyos and Camacho of the La Paz Department, with the objective to promote and support rural development programs.

BACKGROUND

FH/CRECER works, since nine years, with the program "Credito con Educacion". It started its program in 1985 with a baseline study of the nutritional state of rural families in the Altiplano. During the first years of the operation it carried out a variety of activities related to health, agriculture, animal breeding, animal health and others. In 1990, Freedom from Hunger initiated a pilot project with its program "Credito con Educacion" with the intention of implementing a sustainable strategy.

FFH/CRECER established in Bolivia the Civil Association Credito con Educacion Rural "CRECER", a non-governmental institution, with legal status recognized by the Prefecture's Resolution No. 418, which will continue with FFH/CRECER's program Credito con Educacion Rural from July this year.

CSRA is working in the area offering health services since 16 years, initiating activities in the Municipality of Ancoraimes in 1993, in Carabuco in 1984 and in Puerto Acosta in 1996. Through the years it has established a close relationship with the communities, which allowed it to identify the communities needs that go further than the activities developed by the health sector, establishing the necessity of financing little economic activities.

With the effort to institutionalize the coordination between both institutions and in this way to improve the impact of the joint work during the month of October 2000 a collaborative project "Matching Grant-USAID" has been initiated, which covers the municipalities of Ancoraimes, Carabuco and Puerto Acosta in the Department of La Paz.

OBJECTIVES OF THE AGREEMENT

GENERAL OBJECTIVE

The general objective of the present agreement is to achieve the consolidation of the collaborative work in the areas where a previous work existed and to facilitate the entry into new areas improving the efficiency and efficacy of joint actions to jointly help to improve the population's quality of life.

SPECIFIC OBJECTIVES

1. Facilitate the access to quality welfare and preventive service delivery for women and its families, who are members of community bancs in the municipalities of Ancoraimes, Carabuco y Puerto Acosta.

2. Improve the quality and cover of interactive educative activities carried out with the members and their families in the municipalities of Ancoraimes, Carabuco and Puerto Acosta.

3. Measure the impact of conducted activities through the operative teams of both institutions in the areas of intervention.

4. Strengthen the relations of inter-institutional coordination in order to provide the population with a improve service and to improve the conducted work.

OBLIGATIONS, CLAUSES OF FFH/CRECER

1. Inform and program with CSRA the training dates and agenda, which the women from the community bancs will receive in the areas of Ancoraimes, Carabuco and Puerto Acosta with the objective to clearly define the meetings during the ones CRECER will provide educative sessions and CSRA will talk about health related topics.

2. The promoter of CRECER will assist monthly at the meetings of each Information Analysis Comity of the geographic areas to coordinate the health activities. The coordinators of CRECER will assist at the same meetings if the promoter is unable to attend and according to necessity.

3. Make spaces viable for the execution of activities in welfare and preventive health, before and after the carrying out of the community banc meetings.

4. Inform the members about the health services that are provided by the health teams to the municipalities. CRECER will outline a space in "AOB" of the agenda at the community banc meetings where CRECER can promote its health activities. If no staff from CSRA will assist, CRECER will take the responsibility to inform the members about the health services that are provided by CSRA.

5. Carry out the referral of patients for their treatment in the health centers, using the health cards.

6. Formalizing through agreements the coordination between CRECER and the municipal governments in the areas of joint intervention.

OBLIGATIONS, CLAUSES OF CSRA

1. CRECER will be responsible of the training for the board during the promotion phase and its respective reinforcement during the cycle and CSRA will train the person responsible of education from the board incorporating them into its formal program of community leaders.

2. Develop the nutritional rehabilitation program in its components of domestic counseling and interactive educational activity with those mothers and groups that agree to it.

3. Carry out home visits for counseling in Family Planning and High Reproductive Risks to those families that are members of community bancs if they require it.

4. Provide services of curative and preventive health care (Immunizations, Growth Monitoring, Vitamin A) and educational care according to the necessity and possibilities of the health team.

5. Familiarize the CRECER staff and the members of community bancs with the services that the health teams provide to the municipalities and the corresponding costs.

6. Promote the medical, preventive and welfare health care to those patients referred by promoters and the persons responsible for education at the community bancs with preferential costs for medical services, dental services and nursery and only by presenting their cards.

7. Facilitate the formalization of the relationship between CRECER and the municipalities through meetings with the municipal governments.

8. Facilitate the entrance of CRECER into the communities through joint meetings with authorities and members of the communities Ancoraimes, Carabuco and Puerto Acosta.

OF BOTH INSTITUTIONS

1. Socialize the agreement towards all the team members involved directly or indirectly into the implementation of the mentioned.

2. Accomplish with the roles and responsibilities described for the “Matching Grant” project.

3. Give continuity to the formal meetings of follow-up and evaluation of the present agreement and of the Matching Grant Project through:

    - Quarterly meetings of follow-up about the accomplishment of the activities (with the participation of promoters, coordinators, directors from geographic areas, staff responsible for the training, managers and according to necessity other staff).
    - Annual evaluation meetings about the agreement and the achievement analysis of the project with the participation of the executive and managerial staff of both institutions.

4. Interchange quantitative and qualitative information about carried out activities, project evaluations and other research studies that are carried out in the intervention areas, which could be of interest for both institutions.

5. Produce and improve in a joint way the educative and communicational material in self-esteem and sexual and reproductive health, respecting the own methodologies and the author's rights of each institution.

6. Meet periodically to analyze and interchange the information from the reference system.

7. Meet periodically according to necessity and in function of specific coordination tasks.

THIRD

DURATION AND MODIFICATIONS

The present agreement will have a validity of three years, with annual revisions for its periodic evaluation; meetings in which some of the clauses could be modified in mutual agreement with both institutions.

FOURTH

VALIDITY

The present agreement will enter in validity from the signature date and will stay valid at the end of three years, at which date the agreement could be renewed, after previous agreement of both parties.

In case one of the signing parties decides not to continue the agreement, it can be closed after previous notification of 60 days.

FIFTH

JUDGMENT

In case of requiring a judgment, PROCOSI will be asked to form a composed commission of three people to resolve whatever problem.

SIXTH

DELEGATION

Once CRECER initiate its activities, CSRA authorizes and gives its agreement to FFH/CRECER to proceed to the delegation of the emerging obligations of the present agreement in favor of the civil association. FFH/CRECER should communicate through written documents to CSRA and accredit the whole documentation of the legal status to the new association.

SEVENTH

CONFORMITY

The present agreement has been accepted with the signature of the representatives of both institutions, on the 8th of June 2001.

Nathan Robison	Evelyn Grandi Gomez
Director CSRA	General Manager FFH/CRECER

IMPROVEMENT OF THE INFORMATION QUALITY

AGREEMENT BETWEEN THE UNITY OF THE NATIONAL IN HEALTH INFORMATION SYSTEM OF THE HEATLH MINISTRY AND THE CONSEJO DE SALUD RURAL ANDINO

BACKGROUND

The Unity of the Health Information System (from now on SNIS), under the responsibility of the Health Ministry, with office in the Capitan Ravelo street in La Paz, carries out activities, with the eagerness to strengthen the development of the health information system at national level.

The Consejo de Salud Rural Andino (from now on CSRA), is a non-profit organization with office in La Paz – Bolivia, Walter Khon street No. 806, phones 2412405 – 2415752, P.O. Box: 13387. The CSRA developed a primary health care model in two municipalities of the Camacho District (Carabuco and Puerto Acosta) and in the Municipality of Ancoraimes in the Omasuyos District since 1985 under an agreement with the Departmental Health Service La Paz.

JUSTIFICATIONS

The Consejo de Salud Rural Andino, works in economically depressed areas providing services in primary health care, and in this way counting on real quality information about the carried out health interventions is highly important as well as for the Ministry of Health. In order to improve the information quality, the CSRA developed and implemented pilot instruments designed to collect and systemize the information in the Camacho district of La Paz city. Those instruments are completely compatible with the requirements of SNIS. The work was elaborated with the consent of the SNIS unit during the administration 2001.

The evaluation of the whole process demonstrated that the information quality improved outstandingly with regard at the administration 2000. However, during the evaluation also one could observe that it is important to continue strengthening this process to consolidate in the District and the areas CSRA's interventions.

OBJECTIVE

Improve the Health Information Quality in the Camacho District and in other areas under CSRA's responsibility outside of the district.

CLAUSES

This agreement limits the rights and responsibilities of CSRA and the SNIS Unit (from now on the parties) in order to achieve the purpose of the Principal Agreement.

CSRA OBLIGATIONS

Guarantee the improvement of the Health Information System through the use of the Basic Registers in the health centers of the Camacho District and the new health areas under direct influence of CSRA in other Municipalities.

Provide support to the continuous training of health staff in topics related to Information System.

Provide technical support to the Management Team of the District in the outline of a supervision plan, follow-up and monitoring of the local Health Information System.

Accompany the Management Team of the District in its follow-up visits to health centers in order to supervise the Information System.

Provide periodically reports about executed activities to the SNIS Department.

OBLIGATIONS OF THE SNIS UNIT

Provide general politics and new technical norms to incorporate into SNIS.

Authorize and make the use of Basic Registers developed for CSRA, as a component of the Health Information System in all the health centers of the Camacho District and the health centers in the new health areas where CSRA has direct interference.

Participate periodically in supervising processes and according to time availability.

Representative of the SNIS Unity will participate in the evaluation processes at the end of the administration.

VALIDITY THE AGREEMENT

Present agreement enters into force from its date of signature and will have effect for one year, at the end of which it can be terminated, modified or renewed after previous evaluation and common agreement of the contracting parties.

APPROVAL

The SNIS Unit on one hand and the CSRA on the other hand manifest their approval of all the clauses of the present document on the 15th of March 2002.

Dra. Maria Teresa Siles	Lic. Nathan Robison
COORDI NADORA UNIDAD SNIS	DIRECTOR NACIONAL
MINISTERIO DE SALUD Y P.S.	CSRA

AGREEMENT OF INTER-INSTITUTIONAL COORDINATION BETWEEN THE CONSORTIUM TARI – CSRA

The following private agreement, which could become of public character, has been signed by the simple recognition of the signature and part of both parties, as laid down in the following:

FIRST: THE PARTIES

The present agreement has been accepted with the signatures of, on the one hand the Consejo de Salud Rural Andino (CSRA), represented by its National Director Lic. Nathan Robison with office address calle Walter Khon No. 806, La Paz, which will be called from now on CSRA and on the other hand Talleres Abiertos sobre Reciprocidad e Interculturalidad (TARI), represented by its General Secretary Jacqueline Michaux, with office address Av. Buenos Aires No. 706, La Paz, which from now on will be called TARI.

SECOND: THE PURPOSE OF THE AGREEMENT

The purpose of the agreement is the outline of a humanized and intercultural health model from the implementation of the humanization and inter-culturality in health, in the areas of Ancoraimes and Senkata, under the conditions established in the corresponding Annual Plan, as summarized below:

Localization and beneficiary population:

The program is localized in the service net of the municipalities Acoraimes - Omasuyos Province in the Department of La Paz and in the health area covered by the Health Center Senkata, in the 8th district, El Alto in the Department of La Paz.

The actual population living in those areas of intervention is:

Ancoraimes area: 14.044 inhabitants
Senkata area: 10.000 inhabitants

The health staff actually attending in the mentioned areas is:

Ancoraimes area: 20 persons
Senkata area: 4 persons

Purpose:

To validate the humanization and intercultural health program in the mentioned areas.

Expected products:

1. 60% of the health staff and community groups in the areas where there will be worked know, valuate and apply the human, cultural and intercultural rights.

2. 60% of the health staff and community groups and institutions of the areas know and valuate the conceptions and representations of the health practices of both cultures.
3. 30% of the health services and provisions have been adequate humanly and culturally.
4. The inter-institutional relations between the community, the health center and the municipality and other institutions have been strengthened in order to construct and implement the model.
5. The relations between aymara health specialists and health teams have been strengthened.
6. The Humanization and Intercultural Health Program has been validated and systemized for the outline of a Humanized and Intercultural Health Model.

Evaluation Phases:

The implementation phase for this agreement will be evaluated jointly until June 2003 (progress evaluation) and until December 2003 (final evaluation).

THIRD: VALIDITY PERIOD

The period of validity of the Agreement is 12 months and starts on the 2nd of January 2003 until the 31st of December 2003 and the compromises made by TARI for the implementation of the established activities in the Program will be applied.

FOURTH: THE NOMINAL BUDGET OF FINANCING

The total amount of the sub donation previewed in this Agreement is $ 11.349,00, which covers a percentage of the financial requirements of the Program. The remaining balance will be covered with resources from TARI and/or CSRA.

FIFTH: THE SYSTEM of OUTLAY

The funds will be transferred by CSRA and TARI until the 20th of February 2003, in quarterly outlays, with the respective monthly financial reports. Bills will be presented for the expenses, where it is possible and where not the tax's retention will be of 15.5%.

SIXTH: REPORTS FOR CSRA

TARI compromises itself to hand over to CSRA the following periodic reports:

1. **Financial reports:** Quarterly a financial report (at least 15 days after the accomplishment of the trimester).
2. **Technical reports**: Quarterly, a technical narrative report, which contains the analysis of the advances of the activities and the accomplishments in function of the expected products; as well as the encountered problems and the applied solutions (at least 15 days after the accomplishment of the trimester).

SEVENTH: COMPROMISES OF TARI

TARI compromises itself to plan, execute and evaluate the activities established in the Annual Plan 2003 of the mentioned Program according to each hoped product.

At the same time, it accepts the financial revision realized by CRSA, of the sub donation, an activity, which includes the revision and verification of the expenses.

For this purpose, TARI should open a specific banc account in a commercial banc of La Paz, for the administration of funds of the sub donation, which will be transferred by CSRA.

EIGHT: COMPROMISES BY CSRA

CSRA compromises itself to transfer the agreed sub donation amount agreed period..

CSRA compromises itself to support actively TARI so that its members can coordinate the activities with the operative teams of both areas.

CSRA compromises itself to facilitate the coordination of the members of TARI with leaders and community, cantonal authorities, neighbor and municipal boards.

CSRA compromises itself to give the whole support available in the institution to obtain additional resources for the program implementation.

NINTH: COORDINATION OF THE CONSORCIUM

Both institutions compromises themselves to create a "Comity for the Program Implementation", consisting of members of both institutions.

This Comity will meet once a month at least. The number of meetings could be extended according to the needs.

<u>The functions of the Comity are</u>:

a) The elaboration of a five-year plan, which would give continuity to the implementation of the plan.
b) The elaboration of the annual plans in coordination with the operative teams.
c) The monitoring and follow-up of the execution of the annual plan 2003 and its budget.
d) The elaboration and/or revision of the proposals and projects for the continuity of the program.

TENTH: METHOD OF MODIFICATIONS

If during the validity of the present agreement the need is established to carry out modification, which affects its objectives, budget and compromises, this will be processed by approbation of the "Comity of Follow-up to the Implementation of the Program".

If the objectives and goals proposed are not achieved, as well as the obligations of both parties, this could be a reason to rescission of the agreement, after previous evaluation of the Comity of Follow-up.

ELEVENTH: INCUMPLIMIENTO IN THE USE OF FUNDS

In the case in which the use of funds results different than the activities and objectives to which the parties agreed on in the present agreement, TARI compromises itself to the complete reimbursement of the questioned expenses and this could originate the rescission of the present agreement.

TWELFTH: CONFORMITY

Both parties with the approval of the Comity of Follow-up to the Implementation of the Program and with the articles precedents sign the present Agreement of Inter- institutional Coordination in the city of La Paz, on the 28th of February 2003.

Jacqueline Michaux	Nathan Robison
GENERAL SECRETARY	NATIONAL DIRECTOR
TARI	CSRA

INTER-INSTITUTIONAL AGREEMENT BETWEEN THE PROJECTS MANAGEMENT SCIENCE FOR HEALTH – MSH, CONSEJO DE SALUD RURAL ANDINO AND DESARROLLO DEMOCRATICO Y PARTICIPACION CIUDADANA – DDPC

1. Background

The Management and Leadership Project (M&L) is a cooperative agreement of USAID for Management Science for Health and has as central objectives to create and apply the knowledge about management and leadership in the area of international health and to support organizations to confront more effectively changes and to provide high quality health services.

The Consejo de Salud Rural Andino (CSRA) is a private non-profit organization of social development, dedicated to manage local webs of health services in rural and semi-urban areas of depressed economic resources. Actually it provides services in the municipalities of Ancoraimes (Omasuyos Province in the La Paz Department), Puerto Acosta and Carabuco (Camacho Province in the La Paz Department) and Montero (Santa Cruz Department).

Desarrollo Democratico y Participacion Ciudadana (DDPC) is the result of a joint effort between the Bolivian and the American governments, through the United State Agency for International Development (USAID/Bolivia), that seeks to build from the basic foundations of the state – the municipalities – the participative and representative democracy and to make this encounter productive and profitable for all Bolivians without exception.

2. Justification

The signature of this International Agreement corresponds to a strategic alliance for the development of institutional capacities of the municipalities, according to the Law 1551 of Popular Participation and its corresponding regulations that respect the municipal responsibilities in health.

Also, this agreement is in line with the objectives of the involved institutions.

3. Objectives

Diffusion, training and technical assistance in the Model of Participative Municipal Health Management and in the Subsystem of Health Center Control in the Municipalities of the Consejo de Salud Rural Andino in the North of the La Paz Department.

4. Scope/reach and Duration

The Municipalities covered by this agreement are: Ancoraimes (Omasuyos Province, La Paz Department), Puerto Acosta and Carabuco (Camacho Province, La Paz Department). The Duration of this agreement is until the date of achievement of the contract of one of the intervinientes projects.

5. Institutional Compromises

MSH:

Provide training and technical assistance services in the Subsystem of Health Center Control – SCES of the Model of Participative Municipal Health Management and in the CORE application.

CSRA:

Implementation of the Participative Municipal Health Management, the Subsystem of Health Center Control, the CORE and other instruments.

DDPC:

Will train the team of the Consejo de Salud Rural Andino Project for the implementation of the Participative Municipal Health Management and will sumit the technical instruments for the application of the same.

6. Execution of the agreement

ACTIVITY	S	O	N	D
Implementation of the SCES and CORE	X	X	X	
Training of the CSRA team		X		
Implantation of MGMPS		X	X	X

Nathan Robison
DIRECTOR CSRA

Ana Maria Aguilar
DIRECTORA MSH

Thomas K. Reilly
DIRECTOR DDPC

ANNEX F: BASELINE METHODOLOGY AND QUESTIONNAIRES

1. INTRODUCTION AND BACKGROUND

A baseline survey was conducted in the two project sites: the municipal District Eight of El Alto, located in the southern area of the city in the Murillo Province of the La Paz Department, and; three areas in the Municipality of Montero in the northern district of health in the Province of Santiesteban in Santa Cruz (Villa Cochabamba, Cruz Roja and CLEM).

According the National Institute of Statistics, El Alto/District Eight's population at the time of the survey was approximately 35,574 inhabitants. A majority of the population is made-up migrants from the rural area of the neighboring provinces and the mining communities. The principle economic activity is made-up of the informal commerce sector and also includes public sector employment in construction and limited number of craftsmen. The dominant language in the district is Spanish. The baseline survey has been conducted in Spanish by choice of the interviewees, however many inhabitants also speak Aymara. For survey sampling purposes three supervision areas have been identified in this municipality: Cumaravi, Senkata and Atipiri.

CSRA's population in the three areas of Montero was 26,835 and represents 38% of Montero's population total. In the area of Villa Cochabamba, the population consists of mainly migrants from other states such as Cochabamba, La Paz, Sucre, Potosi and Tarija. The majority of inhabitants in the other two areas are not migrants. The principle economic activity for the region is agriculture and other informal sectors and public sector jobs also exist. As was in the case of El Alto, Spanish was used during the survey interviews. While Spanish is the principle language, Aymara is also spoken. The three areas were also selected as supervision areas for the survey.

BASELINE PURPOSE

CSRA's baseline survey seeks to collect and assess the health situation in project areas, which will facilitate planning the implementation of the project in order to better monitor and track the progress of key intervention areas during the life of the project.

The establishment of a baseline for the CS-18 project has been divided into two phases. The first phase consists of conducting a quantitative study with the application of the KPC 2000 surveys and the second consists of conducting qualitative studies (Focal Groups and In-depth Interviews).

2. METHODOLOGY

The KPC 2000 Survey objective is to obtain information about the knowledge and practices of mothers in the care of children under 2, during pregnancy, birth, postpartum, and contraception. The survey also collected information about the population's health status and the coverage of health services in the supervision areas. The understanding of the actual health situation helped identify the priorities and needs of the population, which has allowed project managers to better plan and implement strategies and actions that facilitate the achievement of the project

objectives. This information also serves as a benchmark in the initial parameter for the comparison of information of future evaluations.

To conduct baseline studies the population was divided into three areas of supervision based on the following criteria:

- Population size (seeking balance between the areas)
- Existence and proximity of a health center
- Geographic distribution and extension

This division of the areas of supervision was also supported by:

- The identification of the intervention areas through actualized plans from the Municipalities of El Alto and Montero, according to the Municipal Resolution of November 2002.
- The obtaining of population information from the National Institute of Statistics and population list according to urbanizations from the presidents of neighborhood boards.
- The establishment of an objective population group was identified, which corresponds to non-pregnant mothers with children between 0 and 11 months old and mothers with children between 12 and 23 months old.

INSTRUMENT DESIGN – KPC 2000 FORMS/QUESTIONNAIRES

Data collection instruments were designed for the KPC 2000 – USAID survey, whose content includes the "Rapid Catch" questions, aimed at mothers to obtain information related to Knowledge, Practices and Coverage of maternal health and health care for children under 2 years. Survey questions were developed to collect information according to a pre-defined list of project indicators. This indicators list and its characteristics are mentioned in the following paragraphs of this report.

Survey questionnaires were reviewed, revised and finalized by CSRA's technical central office health staff as well as the health staff in the geographic areas involved in the project. The respective municipal technical teams also reviewed the questionnaires.

Two questionnaires were developed that collected information from 1.) mothers with children between 0 and 11 months; and, 2.) mothers with children between 12 and 23 months of age (see below for questionnaires KPC 2000). The first survey contains questions designed to collect general information: the number of children under 5 years; growth monitoring; nutritional status; vitamin A supplementation; breastfeeding; and the occurrence of diarrhea, pneumonia in the last two weeks. This survey also collected maternal health information such as pregnancies, births, postpartum, HIV/AIDS knowledge, and finally water source and general hygiene. The second survey contains similar questions but also collects information about immunization status and child spacing prevalence.

Validation of instruments to collect the information

To obtain a final version, both surveys had to undergo a pilot validation test in the field. This activity was carried out in neighborhoods outside the intervention area.

INDICATORS INCLUDED IN THE STUDY

The final list of health indicators included in the survey can be found Section A of this report. This list incorporates all of the Rapid Catch indicators; key indicators included in the original CS 18 Project; and, other institutional and prioritized indicators.

DESIGN OF THE SAMPLING

The LQAS (Lot Quality Assurance Sampling) Methodology was used, which is a random sampling method that uses small samples or "lots". The sampling technique allows the project to determine the initial health situation of the area, measure coverage, identify priority areas and identify areas of weaknesses inside the supervision area and between the supervision areas.

As a first step, the urbanizations or neighborhoods were identified in each of the areas of supervision, which were subsequently divided into three sub-sectors.

With the objective to express the mayor part of the results with statistical value and percentage, a number of 19 sets were established in each of the sub-sectors. Assuming that each interview set consists in reality of one survey type 1 and one survey type 2, the total sampling was 342 women (171 women with children under the age of 1 year and 171 women with children between 12 and 23 months). The following tables demonstrates this sampling methodology:

EL ALTO

SUPERVISION AREA	NUMBERS OF SURVEYS TYPE 1	NUMBERS OF SURVEY TYPE 2	NUMBER OF SETS
Senkata	19 + 19 + 19 = **57**	19 + 19 + 19 = **57**	**57**
Cumaravi	19 + 19 + 19 = **57**	19 + 19 + 19 = **57**	**57**
Atipiri	19 + 19 + 19 = **57**	19 + 19 + 19 = **57**	**57**
TOTAL	**171**	**171**	**171**
TOTAL SURVEYS	**342**		

MONTERO

SUPERVISION AREA	NUMBERS OF SURVEYS TYPE 1	NUMBERS OF SURVEY TYPE 2	NUMBER OF SETS
Cruz Roja	19 + 19 + 19 = **57**	19 + 19 + 19 = **57**	**57**
CLEM	19 + 19 + 19 = **57**	19 + 19 + 19 = **57**	**57**
Villa Cbba.	19 + 19 + 19 = **57**	19 + 19 + 19 = **57**	**57**
TOTALES	**171**	**171**	**171**
TOTAL SURVEYS	**342**		

For the establishment of sampling points, following the LQAS methodology, random number tables were used of random numbers after sampling intervals were identified. In this way, sampling points were identified according to neighborhood populations.

TRAINING

SELECTION AND TRAINING OF THE SUPERVISORS

CSRA staff that had previous experience in KPC surveys in other intervention areas carried out the selection, training and supervision of data collection. In addition, within the trained group, select individuals were identified who showed aptitudes to fulfill the roles and functions of a supervisor.

Once the group of supervisors for the survey was identified, they participated in the workshop "Training for Surveys KPC 2000". The principal objective of this activity was to provide key information about the characteristics of the KPC 2000 Survey Study, introducing the KPC 2000 forms, revising the key concepts of the LQAS Methodology, defining the roles and responsibilities besides of the duties and finally planning and organizing the team's field activities.

SELECTION AND TRAINING OF SURVEY TAKERS

Survey interviewees were selected based on the following criteria:

- Persons with basic health knowledge
- Sufficiency in reading and writing
- Preferred knowledge of the Aymara language
- Previous survey experience
- Preference to those who did not live in the survey zone
- Full time availability

The team of survey interviewees constituted of "manzaneras" (community health volunteers) and other health volunteers of the neighborhoods and urbanizations, nursing students, health volunteers who worked before with the CSRA, medicine students and community leaders.

A training plan was designed that identified training subjects, schedule of activities, and facilitators. A three-day training workshop was conducted so that surveyors would get to know each other and learn methods to correctly apply KPC surveys in order to collect accurate information. The contents of the training included also the revision of forms KPC 2000, basic concepts of the LQAS methodology, guides for the correct way of child weight control, norms for the selection and identification of informants, techniques for the survey takers, and roles and functions for the supervisors of survey takers. During the third day, surveyors and supervisors to validate questionnaires carried out another pilot test. Other support materials such as maps of the supervision areas that identified the corresponding urbanizations sampling points were also used.

During the workshop the previously developed survey questionnaires were shared among participants so that the group understood the difference between the two surveys. Participants read through both surveys to fully understand the questionnaires and key information to be collected from target individuals. The workshop was participatory and used exposition techniques, brainstorming, play roles, and workgroup discussions, which were aimed towards practice and the handling of the questionnaires. Visual material (posters, slides and overhead

projectors, photocopy presentations, forms, etc.) and audiovisual materials such as videos were also used.

FIELDWORK – COLLECTION OF INFORMATION

In El Alto 2 survey coordinators, 11 supervisors, 21 survey takers, 2 logistics and one driver were involved in survey collection. The relation during the fieldwork was 1 supervisor for 2 survey takers. Montero had 6 supervisors, 19 surveyors and 1 logistics manager. Two headquarter staff also participated in both surveys.

Survey activities were schedule for three days to collect information at 3 supervision areas. The survey was conducted on January 13-15, 2003 in El Alto and January 16-18, 2003 in Montero. An evaluation of the activities was carried out at the conclusion of each day with the objective to identify the difficulties and doubts occurred during the collection of the information and to seek for solutions for the remainder of the survey.

SUPERVISION OF THE SURVEY

On a daily basis supervisors accompanied the surveyors under their responsibility, prioritized follow-up and provided support and technical assistance. A checklist for surveyors was used during the survey interviews that measured performance and identified weaknesses and problems. Thanks to this instrument a substantial improvement could be obtained in the use of the form and in the development of the interviews within the majority of the survey interviewers. Once the instrument was applied, the supervisors offered feedback that included observations, which strengthened the abilities and individual interview skills. Each supervisor was also responsible to review the survey questionnaires filled out by the surveyors. The survey coordinators also reviewed completed questionnaires.

Household selection

As there not exist family lists, or household maps, the selection of the households was conducted by the use of street maps and plans of the urbanizations. Once an urbanization center was located, the direction was chosen randomly using a spinning bottle. In the case that there was no mother with child in the selected household, the closest house was selected.

If a household had two women with the same characteristics one person was randomly selected by using two little balls of different colors (one for each woman) so that only one woman was interviewed per household.

DATA PROCESSING AND ANALISIS INFORMATION

The information processing used two types of tabulation. A manual tabulation was carried out immediately after fieldwork. A computerized tabulation was carried out simultaneously in order to compare the obtained result of both.

MANUAL TABULATION

This was under the reasonability of CSRA's Health Information System Responsible together with the coordinators and supervisors as well as the administrative staff.

The contents and the chronograms of this workshop are included in the Attachment 9: Chronogram Manual Tabulation Workshop – El Alto.
The main instruments used were the manual tabulation forms proposed by the LQAS methodology (See attachment 10: Manual Tabulation Forms LQAS).
Six groups of two persons were formed. Three of these groups tabulated the forms type 1 and the three groups the other type. During the tabulation process one form from the Cumaravi Area was not taken in to account, making a total of 341 valid surveys.
The information from each survey was then written into the tabulation forms using codes. This information then was consolidated according to supervision areas and in a general form, using different forms designed for this purpose. This tabulation was then revised again to confirm one more the information.

COMPUTARIZED TABULATION

This activity was carried our almost simultaneously to the collection of the information. This activity had the support of the responsible of CSRA's HIS, three tabulators using the version number 6 of EPI INFO. One the results were available they were compared with the manual tabulation, comparing and correcting the differences, in order to obtain reliable final results.

CONSEJO DE SALUD RURAL ANDINO

Base line survey – Child Survival Project CS 18 – December/2002-January/2003
(EL ALTO)

SURVEY FOR MOTHERS WITH CHILDREN BETWEEN 12 AND 23 MONTHS (CHILDREN OLDER THAN 1 YEAR AND YOUNGER THAN 2 YEARS)

Interview set numb ☐☐

Municipality: _____ **Sector**: _____

Neighborhood/Urbanization: _____ **Block Identification**:_____

House number ☐☐☐☐ **Date of the interview:** _____/ 12 / 2002
(day)

Interviewer's name:_____

Supervisor's name: _____**Supervisor's signature** _____

INTRODUCTION AND CONSENT

Dear Lady; we come from the _____ Health Center. This is the center where Consejo de Salud Rural Andino will work jointly with the Mayor's Office and the Ministry of Health. We would like to ask you some questions in relation to the family's health, and especially about the youngest children. These questions are important to improve the health services in this area. The interview will take about 20 minutes. All the information you will provide us will be treated confidentially. Do you agree?

ASK: Do you have any children (boy or girl) between 1 and 2 yeas old? (Between 12 and 23 months)?

(If the answer is negative, thank the mother and explain her that the interview is not possible)

Interviewee's Information

Name: _____**Last names:** _____

1. Age in years: ☐☐

READ: Now I am going to ask you some questions about (child's name) his o her health documentation, nutrition, and what you know about taking care of young children.

INFORMATION ABOUT THE CHILD BETWEEN 12 AND 23 MONTHS:

Names: _____ **Last names:** _____

2. Birth date: _____/_____/ _____/ **Age in months:** ☐☐
(Day / month /year)

Nr.	QUESTIONS	ANSWERS	GO TO..
	3. How many children under 5 years old, beside (child's name), do you have?	Number of children _____ None ……99	→ **5**

4. WRITE THE NAME, BIRTH OF DATE AND SEX FOR EVERY CHILD

NAME	BIRTH DATE	SEX
1) _____	_____/_____/ _____/ (Day / month / year)	FEMALE……..1 MALE…..... 2
2) _____	_____/_____/ _____/ (Day / month / year)	FEMALE……..1 MALE…..... 2
3) _____	_____/_____/ _____/ (Day / month / year)	FEMALE……..1 MALE…..... 2

Growth Monitoring

Nr.	QUESTIONS	ANSWERS	GO TO..
5	Does (child's name) have his or her growth or health card at home? Would you please show it to me?	INFANT HEALTH CARD..... 1 (SHOWED) NO, BUT REFERS SHE OR HE HAS A GROWTH MONITORING RECORD AT HOME OR IN THE HEALHT FACILITY..... 2 HE OR SHE NEVER HAD A HEALTH CARD……..... 3	→ **7** → **7**

6	If the child has any growth monitoring, write down the date of the first control.	DATE OF THE FIRST WEIGTH CONTROL (_____/_____/____) (DAY/MONTH/YEAR)	

7. Ask for the mother's permission to weigh the child, if she agrees, weigh the child; write down the information needed on the boxes below. if she does not agree, leave the column number 1 and write down "3" (denied) in the column number 2.

1 WEIGTH IN GRAMS	2 RESULTADOS 1. Weighted 2. Not present 3. Denied 6. Others
| |	☐

VITAMIN A

Nr	QUESTIONS	ANSWERS	GO TO..
8	**Showing the vitamin "A" capsule, ask:** **Did (child's name) take a Vitamin "A" capsule during the last 6 months?**	YES…….. 1 NO……..... 2 DOES NOT KNOW …….. 99	

IMMUNIZATIONS

The following question is just for children whose mothers showed the immunization card. If the child does not have one skip to question 10

Nr	QUESTIONS	ANSWERS	GO TO..

9.	Look at the inmunization card or other document with immunizations records, and write down the date of every inmunization.	**(STICK THE INMUNIZATION SECTION FROM THE CARD)**	
10.	At what age (child's name) should have had the complete schemed if immunizations?	BEFORE 12 MONTHS OF AGE……..... 1 AT 12 MONTHS OF AGE…..... 2 BETWEEN 12 AND 23 MONTHS…… 3 AFTER 2 YEARS OF AGE..... 4 DOES NOT KNOW..... 99	

CHILD DISEASES

Nr	QUESTIONS	ANSWERS	GO TO..
11	As you know, children sometimes get sick and need attention or treatment. How would you know that your child is seriously ill and you have to look for advice or help urgently? (more than one answer is possible, write down all the answers given by the mother)	LOOKS ILL AND DOES NOT PLAY AS USUALLY……..... 1 DOES NOT EAT OR DRINK..... 2 IS TIRED AND SLEEPY OR DOES NOT WANT TO GET UP..... 3 HAS FEVER……..... 4 RAPID OR DIFFICULT BREATHING ……5 VOMITS THE FOOD…..……..... 6 HAS CONVULSIONS ..... 7 OTHERS _____ 8 (SPECIFY) OTHERS _____ 9 (SPECIFY) DOES NOT KNOW..... 99	

12	Has (child's name) had any of the following health problems during the last 2 weeks? (READ THE OPTIONS TO THE MOTHER) (more than one answer is possible, write down all the answers given by the mother)	DIARRHEA..... 1 BLOOD IN THE EXCREMENT..... 2 DIFFICULT BREATHING..... 4 BREATHING LIKE TIRED ..... 5 MALARIA..... 6 NONE..... 7	→ **17** → **17** → **19** → **19**
13	Did you give breastfeeding to (child's name) during the diarrhea? **(READ THE OPTIONS TO THE MOTHER, ONLY ONE ANSWER ALLOWED)**	MORE THAN USUAL .....1 AS USUAL? ..... 2 LESS THAN USUAL?..... 3 CEASED COMPLETELY? ..... 4 AT THAT TIME DID NOT RECEIVE BREASTFEEDING ANYMORE..... 5	
Nr	**QUESTIONS**	**ANSWERS**	**GO TO..**
14	Did you give other liquids besides breastfeeding to (child's name) during its diarrhea? **(READ THE OPTIONS TO THE MOTHER, ONLY ONE ANSWER ALLOWED)**	MORE THAN USUAL .....1 AS USUAL? ..... 2 LESS THAN USUAL?..... 3 CEASED COMPLETELY? ..... 4 ONLY BREASTFEEDING?..... 5	

15	Did you give solid food or purees to(child's name) during its diarrhea? **(READ THE OPTIONS TO THE MOTHER, ONLY ONE ANSWER ALLOWED)**	MORE THAN USUAL .....1 AS USUAL? ……..... 2 LESS THAN USUAL?..... 3 CEASED COMPLETELY? .....…… 4 ONLY BREASTFEEDING?..... 5	
16	When (child's name) had diarrhea with what did you cure him? (more than one answer is possible, write down all the answers given by the mother)	WITH NOTHING..... 1 ORS PACKET.....…..... 2 CINAMON, BARLEY, OR RICE WATER..... 3 OTHERS _____ 4 (SPECIFY)	

17	Did you ask for advice or help when (child's name) had breathing difficulties?	YES..... 1 NO..... 2 → ***19***	
18	From whom or where did you get advice when (child's name) had breathing difficulties? (more than one answer is possible, write down all the answers given by the mother)	DID NOT GET ADVICE..... 1 HOSPITAL..... 2 HEALTH CENTER…..... 3 PRIVATE PHYSICIAN…..... 4 HEALTH PROMOTER …..... 5 TRADITIONAL HEALER..... 6 DRUG STORE…….. 7 OTHERS_____ *8* (SPECIFY) DOES NOT KNOW..... 99	

READ: Now we will talk about you, about your pregnancy and your health.

PREGNANCY

Nr	QUESTIONS	ANSWERS	GO TO..
19	Did your see anyone for prenatal care while you were pregnant with (child's name) ? Whom did you see? (more than one answer is possible, write down all the answers given by the mother)	PHYSICIAN……..... 1 NURSE…….……..... 2 AUXILIAR NURSE…….. 3 PROMOTER…… . 4 MIDWIFE…….... 5 OTHERS_____ 6 (SPECIFY) NOBODY……..... 7	→22
20	How many times did you have prenatal controls when you were pregnant with (child's name)?	NUMBER OF TIMES_____ DOES NOT REMEMBER..... 99	
21	When you had your prenatal control did you received orientation a bout the following subjects? (READ THE OPTIONS TO THE MOTHER) (more than one answer is possible, write down all the answers given by the mother)	PREPARATIONS FOR DELIVERY…..... 1 BREASTFEEDING……. 2 CHILD SPACING…… 3 IMMUNIZATIONS…… 4 ALARM SINGS DURING PREGNANCY…… 5 NONE……... 6	
22	When you were pregnant with (child's name) did you receive an injection in the arm to prevent the baby from getting tetanus?	SI…….. 1 NO…… 2 DOES NOT KNOW..... 99	

DELIVERY

Nr	QUESTIONS	ANSWERS	GO TO..

23	Who assisted you with the delivery of (child's name? (more than one answer is possible, write down all the answers given by the mother)	MOTHER HERSELF……..... 1 FAMILY MEMBER……..…… 2 TRAINED FAMILY MEMBER..... 3 TRADITIONAL MIDWIFE…. ..... 4 TRAINED MIDVWIFE……..... 5 HEALTH WORKER…..... 6 OTHER _____ 8 **(SPECIFY)** DOES NOT REMEMBER……..... 99	
24	Do you remember what instrument was used to cut the umbilical cord?	NEW RAZON BLADE…..…… 1 SCISSORS..... 2 GLASS.....…..... 3 KNIFE..... 4 OTHERS_____ 5 **(SPECIFY)** DOES NOT REMEMBER..... 99	
25	Do you know the signs of danger for a newborn baby after the delivery? (more than one answer is possible, write down all the answers given by the mother)	WHEN THE BABY IS NOT ABLE TO RECEIVE BREASTFEEDING …….. 1 FAST BREATHING…... ..... 2 REDNESS AROUND THE NAVEL..... 3 DOES NOT CRY..... ..... 4 WHEN THE BABY HAS REDDISCHARGING EYE…….. 5 OTHERS_____ 6 **(SPECIFY)** DOES NOT KNOW……..... 99	
Nr	**QUESTIONS**	**ANSWERS**	**GO**

			TO..
26	Showing the vitamin "A" capsule, ask: Have you ever taken Vitamin "A" during the first 2 months after de delivery of (child's name)?	YES..... 1 NO, NEVER…..... 2 DOES NOT REMEMBER..... 99	
27	Do you know the signs after giving birth when the mother is in danger of dying? (more than one answer is possible, write down all the answers given by the mother)	FEVER……..... 1 EXCESSIVE VAGINAL BLEEDING..... 2 SMELLY VAGINAL DISCHARGE..... 3 OTHERS_____ 4 **(SPECIFY)** DOES NOT KNOW..... 99	

CHILD SPACING

Nr	QUESTIONS	ANSWERS	GO TO..
28	Are you currently pregnant?	YES..... 1 NO..... 2 DOES NOT KNOW..... 99	→ **33**
29	Do you want to have another child during the next 2 years?	YES..... 1 NO..... 2 DOES NOT KNOW..... 99	→ ***32***
30	Are you currently doing something to delay avoid pregnancy?	YES..... 1 NO..... 2	→ ***32***

31	What is the method you or your husband/partner are using now to avoid/postpone getting pregnant?	RHYTHM..... 1 ABSTINENCE..... 2 SURGERY..... 3 INJECTIONS (DEPOPROVERA) ..... 4 PILL..... 5 I.U.D..... 6 CONDOMS..... 7 LACTATIONAL AMNENORRHEA..... 8 COITUS INTERRUPTUS..... 9 OTHERS..... 10 **(SPECIFY)** DOES NOT KNOW..... 99	
32	Do you know any place where you can obtain a child spacing method? (more than one answer is possible, write down all the answers given by the mother)	HEALTH FACILITY..... 1 FAMILY MEMBER..... 2 DRUG STORE..... 3 OTHER_____ 4 **(SPECIFY)** DOES NOT KNOW 99	

HIV/AIDS

READ: Now I am going to ask you some questions about a dessease

33	Have you ever heard of an illness called AIDS?	YES..... 1 NO..... 2	→ **35**

34	Do you know what you can do to avoid getting this illness? (more than one answer is possible, write down all the answers given by the mother)	ABSTAIN FROM SEX……..… 1 USE CONDOMS…..…… 2 FAITHFUL TO ONE PARTNER…….. 3 AVOID SEX WITH PROSTITUTES…….. 4 AVOID INTERCOURSE WITH PERSONS OF THE SAME SEX…… 5 AVOID SEX WITH PERSONS WHO INJECT DRUGS…….…… 6 AVOID BLOOD TRANSFUSIONS……... 7 AVOID KISSING…… 8 AVOID INJECTIONS…..…… 9 AVOID MOSQUITO BITES……..….. 10 SEEK HELP FROM TRADTIONAL HEALER. 11 AVOID SHARING RAZORS OR BLADES…12 OTHERS_____ 13 **(SPECIFY)** OTHERS _____ 14 **(SPECIFY)** DOES NOT KNOW…… 99	

WATER AND SANITATION

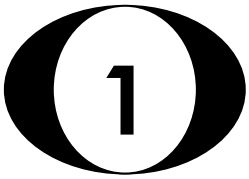
READ: Finally I would like to ask some questions about you home

Nr	QUESTIONS	ANSWERS	GO TO..
35	What is the main source of drinking water for members of you household?	DOMESTIC TAP…..…..1 PUBLIC TAP…..... 2 WATER FROM OPEN WELL..... 3 RAINWATER……..... 4 RIVERWATER..... 5 OTHERS_____ 6 **(SPECIFY)**	

Nr	**QUESTIONS**	**ANSWERS**	**GO TO..**
36	Does your household have a special place for hand washing?	YES..... 1 NO..... 2	→ **38**
37	Ask to see the place used most often for hand washing and observe if the following items are present	WAHTER TAP..... 1 SOAP, ASH OR OTHER CLEANSING AGENT.... 2 BASIN……..…….... 3 PLACE COULD NOT BE OBSERVED……..... 4	
38	When do you wash your hands with soap? (more than one answer is possible, write down all the answers given by the mother)	NEVER..... 1 BEFORE FOOD PREPARATION..... 2 BEFORE FEEDING CHILDREN ..... 3 AFTER DEFECATION…..... 4 AFTER ATTENDING A CHILD WHO DEFECATED……..... 5 OTHERS_____ 6 **(SPECIFY)**	

THANK THE INTERVIEWEE:

Thank you for your time and patience, we hope that this interview will help us to improve the health services in the neighborhood!



CONSEJO DE SALUD RURAL ANDINO

Base line survey – Child Survival Project CS 18 – December/2002-January/2003
(EL ALTO)

SURVEY FOR MOTHERS WITH CHILDREN BETWEEN O AND 11 MONTHS (CHILDREN UNDER 1 YEAR OLD)

Interview set number: ☐☐☐

Municipality: _____ **Sector**: _____

Neighborhood/Urbanization: _____ **Block Identification**:_____

House number ☐☐☐ **Date of the interview:** _____/ 12 / 2002
(day)

Interviewer's name:_____

Supervisor's name: _____**Supervisor's signature** _____

INTRODUCTION AND CONSENT

Dear Lady; we come from the _____ Health Center. This is the center where Consejo de Salud Rural Andino will work jointly with the Mayor's Office and the Ministry of Health. We would like to ask you some questions in relation to the family's health, and especially about the youngest children. These questions are important to improve the health services in this area. The interview will take about 20 minutes. All the information you will provide us will be treated confidentially. Do you agree?

ASK: Do you have any children (boy or girl) under 1 year old? (Between 0 and 11 months)?

(If the answer is negative, thank the mother and explain her that the interview is not possible)

Interviewee's Information

Name: _____**Last names:** _____

1. Age in years : ☐☐

READ: Now I am going to ask you some questions about (child's name) his o her health documentation, nutrition, and what you know about taking care of young children.

INFORMATION ABOUT CHILD UNDER 1 YEAR OLD (FROM 0 TO 11 MONTHS):

Names: _____ **Last names:** _____

2. Birth date: _____/_____/ _____/ **Age in months:** ☐☐
(Day / month /year) (**IF THE CHILD IS 0 TO 29 DAYS OLD WRITE R.B.-Recently Born)**

Nr.	QUESTIONS	ANSWERS	GO TO..
	3. How many children under 5 years old, beside (child's name), do you have?	Number of children _____ None ……99	→ **5**

4. WRITE THE NAME, BIRTH OF DATE AND SEX FOR EVERY CHILD

NAME	BIRTH DATE	SEX
1) _____	_____/_____/ _____/ (Day / month / year)	FEMALE…….1 MALE…..... 2
2) _____	_____/_____/ _____/ (Day / month / year)	FEMALE…….1 MALE…..... 2
3) _____	_____/_____/ _____/ (Day / month / year)	FEMALE…….1 MALE…..... 2

GROWTH MONITORING

Nr.	QUESTIONS	ANSWERS	GO TO..
5	Does (child's name) have his or her growth or health card at home? Would you please show it to me?	INFANT HEALTH CARD..... 1 (SHOWED) NO, BUT REFERS SHE OR HE HAS A GROWTH MONITORING RECORD AT HOME OR IN THE HEALHT FACILITY..... 2 HE OR SHE NEVER HAD A HEALTH	→ **7** → **7**

		CARD……..... 3	
6	If the child has any weigh control, write down the date of the first control.	DATE OF THE FIRST WEIGTH CONTROL (_____/_____/____) (DAY/MONTH/YEAR)	

7. Ask for the mother's permission to weigh the child, if she agrees, weigh the child; write down the information needed on the boxes below. if she does not agree, leave the column number 1 and write down "3" (denied) in the column number 2.

1 WEIGTH IN GRAMS	2 RESULTADOS 1. Weighted 2. Not present 3. Denied 6. Others
☐☐☐☐☐	☐

VITAMIN A

(Question only valid for children from six month of age– if the child is under 6 months go to question nr. 9)

Nr	QUESTIONS	ANSWERS	GO TO..
8	**Showing the vitamin "A" capsule, ask:** ¿Did (child's name) take a Vitamin "A" capsule during the last 6 months?	YES…….. 1 NO……..... 2 DOES NOT KNOW …….. 99	

BREASTFEEDING

Nr	QUESTIONS	ANSWERS	GO TO..
9	Have you ever given breastfeeding to (child's name)?	YES…….. 1 NO……..... 2	→**12**

10	What types of liquids and food have you given to (child's name) yesterday? (more than one answer is possible, write down all the answers given by the mother)	WATER..... 1 BREASTFEEDING…..... 2 JUICES O SOFT DRINKS..... 3 TEA, COFFEE, HERBAL TEA..... 4 SOUPS..... 5 FOOD FROM MOTHER'S DISH..... 6 FRUITS..…..... 7 PUREES…..... 8 OTHERS _____ 9 **(SPECIFY)** OTHERS _____ 10 **(SPECIFY)** OTHERS _____ 11 **(SPECIFY)**	
Nr	**QUESTIONS**	**ANSWERS**	**GO TO..**
11	How long after the birth of (child's name) did you start breastfeeding?	DURING THE FIRST HOUR AFTER THE DELIVERY……..... 1 AFTER THE FIRST HOUR OF THE DELIVERY……..... 2 DOS NOT REMEMBER….....99	

CHILD DISEASES

Nr	QUESTIONS	ANSWERS	GO TO..
12	As you know, children sometimes get sick and need attention or treatment. How would you know that your child is seriously ill and you have to look for advice or help urgently? (more than one answer is possible, write down all the answers given by the mother)	LOOKS ILL AND DOES NOT PLAY AS USUALLY……..... 1 DOES NOT EAT OR DRINK..... 2 IS TYRED AND SLEEPY OR DOES NOT WANT TO GET UP..... 3 HAS FEVER……..... 4 RAPID OR DIFFICULT BREATHING ……5 VOMITS THE FOOD…..……..... 6 HAS CONVULSIONS ..... 7 OTHERS _____ 8 **(SPECIFY)**	

		OTHERS _____ 9 **(SPECIFY)** DOES NOT KNOW..... 99	
13	Has (child's name) had any of the following health problems during the last 2 weeks? (READ THE OPTIONS TO THE MOTHER) (more than one answer is possible, write down all the answers given by the mother)	DIARRHEA..... 1 BLOOD IN THE EXCREMENT..... 2 DIFFICULT BREATHING..... 4 BREATHING LIKE TIRED ..... 5 MALARIA..... 6 NONE..... 7	→ **18** → **18** → **20** → **20**
Nr	**QUESTIONS**	**ANSWERS**	**GO TO..**
14	Did you give breastfeeding to (child's name) during the diarrhea? **(READ THE OPTIONS TO THE MOTHER, ONLY ONE ANSWER ALLOWED)**	MORE THAN USUAL .....1 AS USUAL? ..... 2 LESS THAN USUAL?..... 3 CEASED COMPLETELY? ..... 4 AT THAT TIME DID NOT RECEIVE BREASTFEEDING ANYMORE..... 5	

15	Did you give other liquids besides breastfeeding to (child's name) during its diarrhea? **(READ THE OPTIONS TO THE MOTHER, ONLY ONE ANSWER ALLOWED)**	MORE THAN USUAL .....1 AS USUAL? ……..... 2 LESS THAN USUAL?..... 3 CEASED COMPLETELY? .....…… 4 ONLY BREASTFEEDING?..... 5	
16	Did you give solid food or purees to(child's name) during its diarrhea? **(READ THE OPTIONS TO THE MOTHER, ONLY ONE ANSWER ALLOWED)**	MORE THAN USUAL .....1 AS USUAL? ……..... 2 LESS THAN USUAL?..... 3 CEASED COMPLETELY? .....…… 4 ONLY BREASTFEEDING?..... 5	
17	When (child's name) had diarrhea with what did you cure him? (more than one answer is possible, write down all the answers given by the mother)	WITH NOTHING..... 1 ORS PACKET.....…..... 2 CINAMON, BARLEY, OR RICE WATER..... 3 OTHERS _____ 4 (SPECIFY)	

Nr	QUESTIONS	ANSWERS	GO TO..
18	Did you ask for advice or help when (child's name) had breathing difficulties?	YES..... 1 NO..... 2	→ ***20***
19	From whom or where did you get advice when (child's name) had breathing difficulties?	DID NOT GET ADVICE..... 1 HOSPITAL..... 2 HEALTH CENTER…..... 3	

	(more than one answer is possible, write down all the answers given by the mother)	PRIVATE PHYSICIAN…..... 4 HEALTH PROMOTER …..... 5 TRADITIONAL HEALER..... 6 DRUG STORE…….. 7 OTHERS_____ 8 (SPECIFY) DOES NOT KNOW..... 99	

READ: Now we will talk about you, about your pregnancy and your health.

PREGNANCY

Nr	QUESTIONS	ANSWERS	GO TO..
20	Did your see anyone for prenatal care while you were pregnant with (child's name) ? Whom did you see? (more than one answer is possible, write down all the answers given by the mother)	PHYSICIAN……..... 1 NURSE…….……..... 2 AUXILIAR NURSE…….. 3 PROMOTER…… . 4 MIDWIFE…….. 5 OTHERS_____ 6 (SPECIFY) NOBODY……..... 7	→**23**
21	How many times did you have prenatal controls when you were pregnant with (child's name)?	NUMBER OF TIMES_____ DOES NOT REMEMBER..... 99	

Nr	QUESTIONS	ANSWERS	GO TO..
22	When you had your prenatal control did you received orientation a bout the following subjects? (READ THE OPTIONS TO THE MOTHER)	PREPARATIONS FOR DELIVERY…..…. 1 BREASTFEEDING…… 2 CHILD SPACING…… 3 IMMUNIZATIONS…… 4	

	(more than one answer is possible, write down all the answers given by the mother)	ALARM SINGS DURING PREGNANCY…… 5 NONE…….. 6	
23	When you were pregnant with (child's name) did you receive an injection in the arm to prevent the baby from getting tetanus?	SI…….. 1 NO…… 2 DOES NOT KNOW..... 99	

DELIVERY

Nr	QUESTIONS	ANSWERS	GO TO..
24	Who assisted you with the delivery of (child's name? (more than one answer is possible, write down all the answers given by the mother)	MOTHER HERSELF……..... 1 FAMILY MEMBER……..…… 2 TRAINED FAMILY MEMBER..... 3 TRADITIONAL MIDWIFE…. ..... 4 TRAINED MIDVWIFE……..... 5 HEALTH WORKER…..... 6 OTHER _____ 8 **(SPECIFY)** DOES NOT REMEMBER……..... 99	
25	Do you remember what instrument was used to cut the umbilical cord?	NEW RAZON BLADE…..…… 1 SCISSORS..... 2 GLASS.....…..... 3 KNIFE..... 4 OTHERS_____ 5 **(SPECIFY)** DOES NOT REMEMBER..... 99	
Nr	**QUESTIONS**	**ANSWERS**	**GO TO..**

26	Do you know the signs of danger for a newborn baby after the delivery? (more than one answer is possible, write down all the answers given by the mother)	WHEN THE BABY IS NOT ABLE TO RECEIVE BREASTFEEDING …….. 1 FAST BREATHING…... ..... 2 REDNESS AROUND THE NAVEL..... 3 DOES NOT CRY..... ..... 4 WHEN THE BABY HAS REDDISCHARGING EYE…….. 5 OTHERS_____ 6 **(SPECIFY)** DOES NOT KNOW…..... 99	
27	Showing the vitamin "A" capsule, ask: Have you ever taken Vitamin "A" during the first 2 months after de delivery of (child's name)?	YES..... 1 NO, NEVER…..... 2 DOES NOT REMEMBER..... 99	
28	Do you know the signs after giving birth when the mother is in danger of dying? (more than one answer is possible, write down all the answers given by the mother)	FEVER……..... 1 EXCESSIVE VAGINAL BLEEDING..... 2 SMELLY VAGINAL DISCHARGE..... 3 OTHERS_____ 4 **(SPECIFY)** DOES NOT KNOW..... 99	

HIV/AIDS

READ: Now I am going to ask you some questions about a dessease

29	Have you ever heard of an illness called AIDS?	YES..... 1 NO..... 2	→ **31**
Nr	**QUESTIONS**	**ANSWERS**	**GO TO..**

30	Do you know what you can do to avoid getting this illness? (more than one answer is possible, write down all the answers given by the mother)	ABSTAIN FROM SEX……..… 1 USE CONDOMS……. 2 FAITHFUL TO ONE PARTNER…….. 3 AVOID SEX WITH PROSTITUTES…….. 4 AVOID INTERCOURSE WITH PERSONS OF THE SAME SEX……. 5 AVOID SEX WITH PERSONS WHO INJECT DRUGS……. 6 AVOID BLOOD TRANSFUSIONS……... 7 AVOID KISSING……. 8 AVOID INJECTIONS……. 9 AVOID MOSQUITO BITES……..….. 10 SEEK HELP FROM TRADTIONAL HEALER. 11 AVOID SHARING RAZORS OR BLADES…12 OTHERS_____ 13 **(SPECIFY)** OTHERS _____ 14 **(SPECIFY)** DOES NOT KNOW……. 99	

WATER AND SANITATION

READ: Finally I would like to ask some questions about you home

Nr	QUESTIONS	ANSWERS	GO TO..
31	What is the main source of drinking water for members of you household?	DOMESTIC TAP…….....1 PUBLIC TAP…..... 2 WATER FROM OPEN WELL..... 3 RAINWATER……..... 4 RIVERWATER..... 5 OTHERS_____ 6 **(SPECIFY)**	
Nr	**QUESTIONS**	**ANSWERS**	**GO TO..**

32	Does your household have a special place for hand washing?	YES..... 1 NO..... 2	→ **34**
33	Ask to see the place used most often for hand washing and observe if the following items are present	WAHTER TAP..... 1 SOAP, ASH OR OTHER CLEANSING AGENT.... 2 BASIN……..……..... 3 PLACE COULD NOT BE OBSERVED……..... 4	
34	When do you wash your hands with soap? (more than one answer is possible, write down all the answers given by the mother)	NEVER..... 1 BEFORE FOOD PREPARATION..... 2 BEFORE FEEDING CHILDREN ..... 3 AFTER DEFECATION…..... 4 AFTER ATTENDING A CHILD WHO DEFECATED……..... 5 OTHERS_____ 6 **(SPECIFY)**	

THANK THE INTERVIEWEE:

Thank you for your time and patience, we hope that this interview will help us to improve the health services in the neighborhood!

ANNEX G: QUALITY ASSURANCE

The quality assurance program, which will be implemented within the CS 18 Project, consists of three workshops. In each of these workshops the participants will learn to use certain instruments, which will be applied with support and follow up during the time between workshops. The results of the applications will be presented in the workshops where feedback is also received.

During the **first workshop**, after reviewing the conceptual and methodological framework of the quality of care, standards will be defined for instances of other services. A quality assurance team defines their own standards, that follow a format that contains: standard, indicator, formula, numerator source, denominator source, periodicity and responsible. Team standards will be defined in relation to the IMCI strategy and the mother care model for maternal health.

After the initial workshop forms will be prepared and or adapted in order to measure the standards. Checklists as well as surveys according to the selected standards will be used. Instructions will be developed or adapted to ensure that forms are completed accurately. Staff will be trained to effectively fill out of the forms and the indicators of the selected standards will be measured. Results in the form of tables and graphs will be prepared which will be presented at the second workshop.

During the **second workshop** results from the revision of standards will be presented and then the team will work in relation to the methodological approach for the quality improvement. The different instruments will be presented that will support in the team the analysis of the problem indicators and the solutions of them. These principal instruments include: Form A, for quick solutions of problems and Form B for problem solutions based on teams, which will be useful for the prioritization and operational definition of problems, which affect the quality. As soon as the problems are identified, the problem analysis is carried out with Ishikawa diagram or fish spine. Finally, the activity planning matrix will be designed to resolve the identified problems.

After the second workshop the measurement of standards will continue, on a monthly basis. Simultaneously, the quality assurance team in the workshop stats to develop activities from its activity plan developed in the workshop, and one after one, the identified problems will be developed using the instruments developed in the second workshop. The participant team in the workshops also meet to analyze the indicators' evolution and to monitor the accomplishment of the activity plan. There exist forms to monitor de implementations evolution.

Another activity, which will be carried out before to the third workshop, is the application of the satisfaction survey of the client. This survey is adapted according to the needs of the area and will be applied after a training of the survey takers. This is a exit survey of the health services which does not require much logistical preparations.

During the **third workshop** the results of the survey will be presented and a problem analysis and solutions will take place. With the same methodology of the second workshop, ad as well during this workshop, the subject of group cohesion and team development will be discussed. The activities, which continue the third wokshop, are the periodic measuring of standards, the problem analysis, the implementation of activities and the monitoring of the plan accomplishments.

Organization. In each geographical area where the program will be implemented, a quality improvement team will be formed. Each time has a facilitator who supports his team during the program implementation. In the central office of La Paz, the roll of the technical team members, participating in the workshop is to prepare the workshops in coordination with the facilitators. Another roll is to provide technical assistance for the continuity of the implementation and its sustainability.

The participation of the technical members is not only limited to the carrying out of the workshops but also, after each meeting, there are visits to the geographical areas for follow up and companionship for implementation activities. These visits will be programmed according to needs of the facilitators.

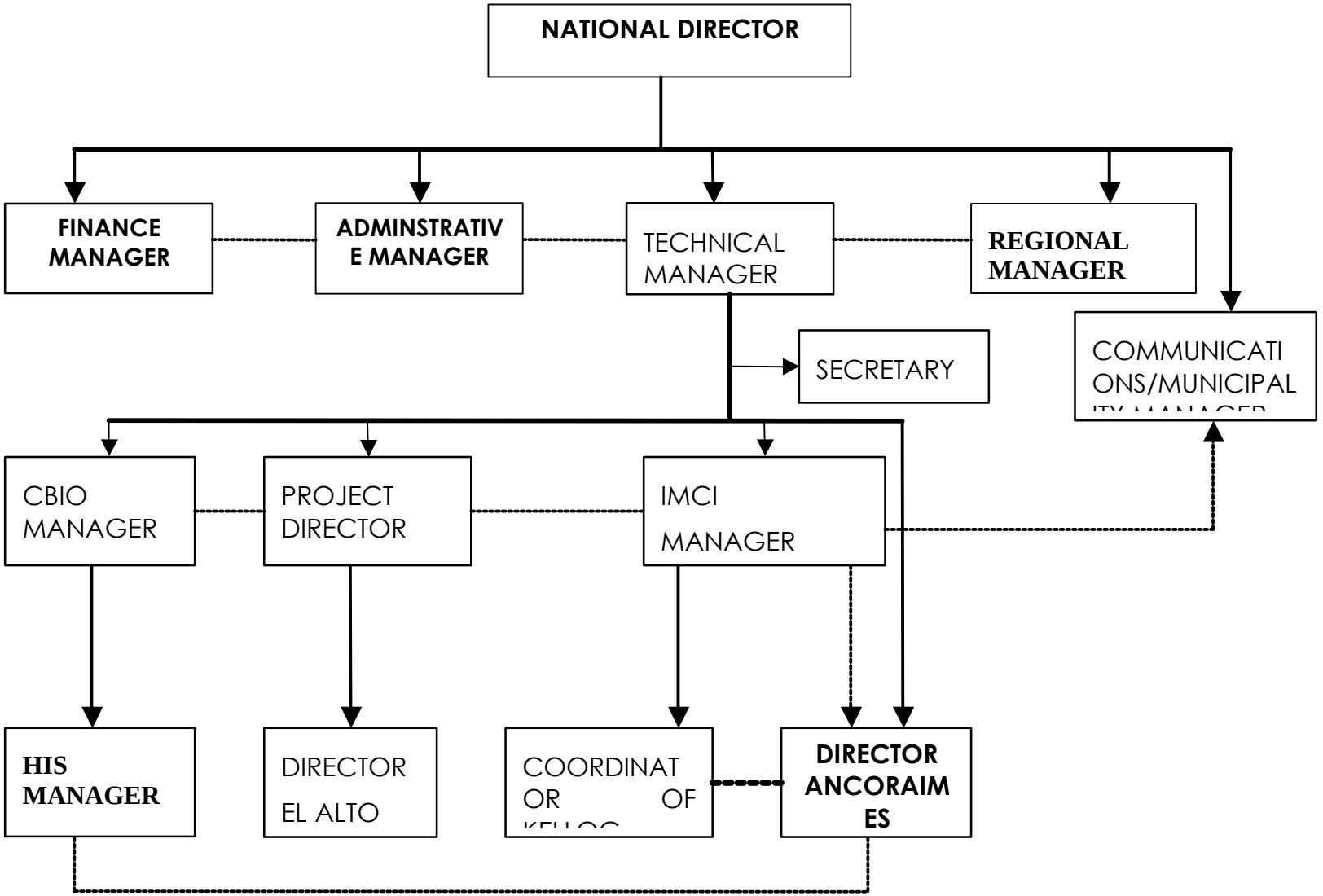
Information System. All the information produced in the geographical area is summarized in two monthly forms, which will be sent to the Central office. The member of the technical team should provide feedback on a monthly basis to the facilitators. The most important qualitative and quantitative conclusions of the process will be informed to the donors through periodical reports.

It is not possible to describe how in each intervention the program of continuous quality improvement will be applied. The team defines its standards and prioritizes its problems. The CSRA will propose to the teams to work in relation to the standards and the problems related to the mentioned interventions of the project.

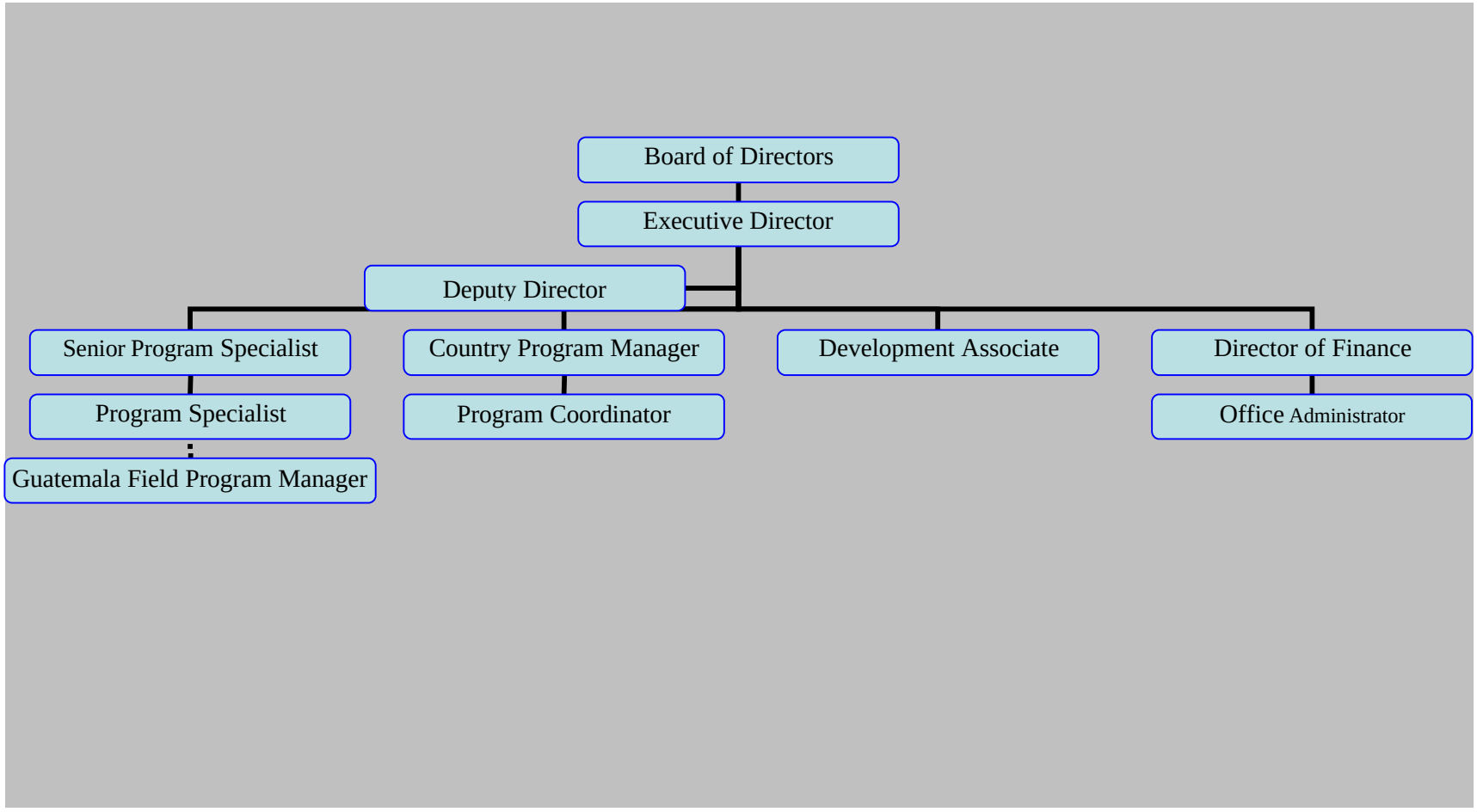
An example of the application of the methodology is the following: The identified indicator for the Villa Cochabamba 's team is: the percentage of women attended by health staff in home visits or in service during their first control and who have clinic history correctly and completely filled out. The form contains 31 items, which should be filled out in every clinic history. The measures for this standard of all of the clinic histories reviewed each month from July on are: 8%, 13%, 0%, 4%, 29% and 78% respectively. The indicator was identified as the most important problem. Within the causes identified it was observed that the responsibility to fill out the clinical history was not defined and as well that the Pap Nicolao results were not attached to the clinical history. Within the planed activities to resolve the problem were: the delivery of the guide for the correct fill out of the clinical history by the responsible of the out-reach services. The responsible of the out-reach services will define together with the health team the correct way to fill out the clinic history. In the meetings of monitoring of analysis of the indicators a follow up to the problem was carried out and little by little a quality improvement could be observed.

ANNEX H: ORGANIZATIONAL CHARTS

CSRA'S ORGANIZATIONAL CHART



Curamericas Headquarters Organizational Chart



ANNEX I: JOB DESCRIPTIONS

Job Description
TECHNICAL MANAGER/DIRECTOR

STRATEGIC OBJECTIVES

Supply the organizational teams permanently with information, methodologies and instruments to obtain better practices (internal and external) in the field of public health to assure an institutional and competitive leader position in the field of action and with the capacity to offer ones products.

Assure that the CSRA has the technical knowledge to reach the MEGA.

PRINCIPAL RESPONSABILITIES

1. Planning, monitoring and evaluation

1.1 Elaborate a annual plan from the strategic products at his charge.
1.2 Assure the incorporation of objectives and goals of the areas at his charge in the POA of the geographic areas.
1.3 Realize the monitoring and follow-up of the institutional areas and programs at his charge.
1.4 Elaborate periodical reports about the advance of his POA at the corresponding moments.
1.5 Coordinate with the person in charge of the geographic and regional areas the implementation, monitoring, follow-up and evaluation of the institutional projects of gender and SSR CARE.

2. Technical assistance

2.1 Revise the bibliography, participate in technical events about the best-used practices in the field of public health and present a selected list of methodologies and tools that the organization could incorporate.
2.2 Participate and support actively the outline and implementation of the Intercultural Approach in the provision of health services.
2.3 Systemize the experiences of the validation of these methodologies and strategies assure the presence of manuals.
2.4 Support the one who need help in the implementation and dissemination of those methodologies and strategies in the whole organization.
2.5 Systemize the experiences and/or successful institutional projects including the elaboration of manuals.
2.6 Head the pilot implementation of an institutional program to improve continually the quality and to support in a permanent way, if needed, in the dissemination at all levels of the organization.
2.7 Head the institutional pilot implementation of a supervising system and support, depending on necessity, in its dissemination.

2.8 Head the pilot validation processes of other methodologies and innovating strategies on the market.

3. Financial administration

3.1 Elaborate the corresponding budget of his POA.
3.2 Carry out the periodic follow-up of the financial implementation of the institutional areas and programs at his charge.

4. Institutional and Group Strengthening

4.1 Head in coordination with the National Director and other Managers the outline and implementation of the Strategic Institutional Plan.
4.2 Promote actively the development of the group cohesion of his team and participate actively with the latter in activities, which contribute to the achievement of MEGA.
4.3 Establish ideals levels of coordination and communication within the group and with other groups as well within the organization as within the geographic unities of La Paz.
4.4 Show an ethical and transparent attitude and conduct before the strategic partners and members of the team.
4.5 Participate actively in the local authorities of decision-taking (different comities)
4.6 Represent the organization at coordination meetings and other external activities.

Job Description

INSTITUTIONAL RESPONSIBLE OF CHILD SURVIVAL PROJECT CS-18
(TECHNICAL ADVISOR III)

STRATEGIC OBJECTIVES

Assure the implementation of the strategies and interventions as well as the accomplishment of the proposed objectives and goals in the CS-18 Project at the levels of all geographic areas.

PRINCIPAL RESPONSIBILITIES

1. Planning, monitoring, supervision and evaluation

1.1 Elaborate an Operative Annual Plan from the strategic products under his responsibility.
1.2 Assure in coordination with the Directors of the Geographic Areas the incorporation of the CS-18 project key activities into the POA.
1.3 Monitor quarterly the indicators of the Child Survival Project CS-18 besides the technical progress of the POA and provide feedback to the corresponding authorities.
1.4 Carry out the follow-up in the field of the implementation of key activities of the Child Survival Project CS-18, through periodical visits to the geographic areas.
1.5 Accompany the Directors of geographic areas of the project en the quarterly evaluation processes in the areas where he is in charge.

1.6 Take responsibility for the timely elaboration of the periodical reports of the Child Survival Project CS-18 to send to Curamericas and the corresponding institutions (Managers, National Director and/or partners, and allies if necessary).
1.7 Coordinate, as counterpart of CSRA, the establishment of a Base Line, the evaluations of midterm and final evaluations of the CS-18 Child Survival Project.
1.8 Take responsibility for the carrying out of the Survey of the Final CPC Evaluation of the Project.
1.9 Coordinate the field visits of representatives from USAID Bolivia and Washington.

2. Co-management

2.1 Support, following necessity, the person responsible institutionally of the co-management and the decision takers of the regional geographic areas in the consolidation of the strategy of co-management and the establishment of ideal relations con their local, regional and national counterparts.

3. Program Implementation

3.1 In coordination with the designed person if the technical team, carry out the follow-up of the implementation, the follow-up and evaluation of the AIEPI Strategy (Clinical and Communitarian) in the geographic areas.
3.2 Take responsibility for the implementation, follow-up and evaluation of the Nutritional Strategy in the geographic areas of the project.
3.3 In coordination with the designed person of the technical team, carry out follow-up of the training and follow-up for the implementation of the Census Based of Methodology in the geographic and regional areas.
3.4 Support the designed person of the technical team in the follow-up of the implementation of the Communication and Communitarian Mobilization Strategy based on leaders.

4. Financial Administration

4.1 Head the annual processes of the budgetary planning of the project in coordination with the Administrative and Financial Management and the Directors of the Geographic Areas.
4.2 Assure the articulation between the POAs of the geographic areas and the CS-18 Child Survival Project with the financial planning in coordination with the Administrative and Financial Management and the Regional Management.
4.3 Support the Directors of the geographic areas and coordinate with the regional managers the follow-up of the budgetary implementation of the geographic areas and the CS-18 Child Survival Project.
4.4 Monitor periodically the budgetary carry out of the CS-18 Child Survival Project in coordination with the Administrative and Financial Management.
4.5 Supervise the timely preparation of the financial reports of the CS-18 Child Survival Project.

5. Technical Assistance

5.1 Head the identification, selection and contract of consultants for technical assistance in the country and provide accompaniment according to necessity.
5.2 Coordinate with Curamericas the identification, selection and contract of international technical assistance and provide accompaniment according to necessity.
5.3 Support, according to possibilities, the National Director in the outline of activities for the institutional projects.

6. Institutional and group strengthening

6.1 Contribute in the achievement of an ideal level of coordination and communication within the La Paz office and between the La Paz office and the directors and groups from the geographic areas.
6.2 Promote actively the cohesion and development of the technical team.
6.3 Show an ethical and transparent attitude and conduct before the strategic partners and members of the group.
6.4 Participate actively in the local decision-taking institutions (Implementation Comity, etc.).
6.5 Represent the institution and other external activities.
6.6 Support according to necessity the administrative manager and the operational manager in visiting activities, working teams and donations.

Job Description
INSTITUTIONAL RESPONSIBLE OF
IMCI STRATEGY
(TECHNICAL ADVISOR II)

STRATEGIC OBJECTIVES

Guarantee results and show the impact exercising leadership in all the technical fields under his responsibility.

PRINCIPAL RESPONSIBILITIES

1. Planning, monitoring, supervising and evaluation.

1.1 Elaborate an operative annual plan from the strategic products under his responsibility.
1.2 In coordination with the Directors of the Geographic Areas assure the incorporation into the POA of the key activities of the technical areas under his responsibility.
1.3 Monitor quarterly the technical advances of the technical areas under his responsibility and provide feedback to the corresponding authorities.
1.4 Carry out the field follow-up of the implementation or elaboration of technical activities under his responsibility through periodic visits to the geographic areas.

1.5 Accompany, according to possibility, the Directors in the quarterly evaluation process in the areas under his responsibility in the corresponding technical areas.
1.6 Prepare executive reports (of the areas under his responsibility for the Managers, National Director and/or partners, financial backer and allies if necessary).

2. Program Implementation

2.1 Take responsibility for the channel of training activities, supervising and carrying out of follow-up and the evaluation of the implementation of the AIEPI strategy in his clinical and communitarian components all geographic unit levels of the CSRA.
2.2 Support the administrative management, in the implementation of the program Guarantee for Quality at the level of the La Paz office.
2.3 Support, according to necessity, the establishment of Baseline, Midterm Evaluations and Final Evaluations of the projects.
2.4 Head the institutionalization of the SIVIECO model.
2.5 Head the formulation of the SIVIECO model adapted to production and development.

3. Financial Administration

3.1 Elaborate the budget for the Operative Annual Plan and de institutional projects and programs under his responsibility in coordination with the financial manager and the directors of the geographic areas.
3.2 Carry out the periodic follow-up for the budgetary implementations of the Operative Annual Plan budget and the projects and programs under his responsibility.
3.3 Supervise the timely preparation of the financial reports of the institutions projects and programs under his responsibility.

4. Institutional and group strengthening

4.1 Contribute in the achievement of an ideal level of coordination and communication within the La Paz office and between the La Paz office and the directors and groups from the geographic areas.
4.2 Promote actively the cohesion and development of the technical team.
4.3 Show an ethical and transparent attitude and conduct before the strategic partners and members of the group.
4.4 Participate actively in the local decision-taking institutions (Implementation Comity, etc.).
4.5 Represent the institution and other external activities.

Job Description
INSTITUTIONAL RESPONSIBLE
CENSUS BASED METHODOLOGY
(TECHNICAL ADVISOR I)

STRATEGIC OBJECTIVES

Assure quality, effectiveness, efficiency and leadership in the accomplishment of all responsible technical areas at his charge.

PRINCIPAL RESPONSIBILITIES

1. Planning, supervision and evaluation

1.1 Elaborate an operative annual plan from the strategic products at his charge.
1.2 Establish strategic guidelines and an implementation plan, monitoring, follow-up and evaluation of the Census Based Methodology.
1.3 Support the directors of the Geographic Areas in the monitoring process, follow-up and the evaluation of the census Based Methodology.
1.4 Carry out the evaluation of the Census Based Methodology in all the geographic and regional Areas.
1.5 Assure the incorporation of objectives and aims of the projects or institutional programs at his charge in the operative annual plans of the geographic areas at his charge.
1.6 Carry out monitoring and follow-up of the projects and institutional programs at his charge.
1.7 Accompany, if possible, the Directors in the process of quarterly evaluations in the areas at his charge in the technical areas under his responsibility.
1.8 Prepare executive reports (in the areas under his responsibility for the Managers and National Director and/or the partners, financers and allies if necessary)
1.9 Coordinate the execution of evaluations of the projects and institutional programs under his responsibility.
1.10 Take responsibility for the accompaniment and follow-up of the person in charge of the Information System of the institution.

2. Implementation of Programs and Projects

2.1 Support the Regional (Montero) and Directors of the geographic areas in the implementation process of the Census Based Methodology
2.2 Take responsibility for the diffusion of the census based methodology through the elaboration of publications and organization of promotional events, training and others.

3. Technical Assistance

3.1 Systemize the experiences of the census-based methodology from the results of the evaluation.

3.2 Provide technical assistance to the Directors of Geographic and Regional Areas in the implementation of other projects and institutional programs according to need.
3.3 Coordinate the execution of investigations assigned to his charge.
3.4 Provide technical assistance to the responsible of the Information System for the implementation of activities included in his POA.

4. Financial Administration

4.1 Elaborate the budget for the Operative Annual Plan and the institutional Projects and Programs at his charge in coordination with the Financial Manager and the directors of the geographical Areas.
4.2 Carry out the periodic follow-up to the implementation budgetary of the budget from his Operative Annual Plan and the projects and programs at his charge.
4.3 Supervise the timely preparation of the financial reports of the institutional programs and projects at his charge.

5. Group and Institutional Strengthening

5.1 Support the responsible of the Information System in the strengthening and development of managerial skills necessary for its job.
5.2 Contribute to the achievement of an optimal level of coordination and communication at the inside of the team at the La Paz office and between the La Paz office and the directors and teams of the geographic areas.
5.3 Promote actively the group cohesion and the development of the technical group.
5.4 Show an attitude, ethical conduct and transparency towards his group and with the groups of the Geographic Areas, putting in practice the institutional values.
5.5 Participate in all the meetings of institutional decision-taking (Implementation Comity, etc.)
5.6 Represent the institution and other external activities.